MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 8, 2005, 11:12 a.m. *

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: Good morning everybody. Welcome to our
3 audience to another MedPAC year. And welcome to Nancy Kane,
4 a public welcome to Nancy, a new commissioner. Jennie Chin
5 Hansen, who is another new commissioner, is not at this
6 meeting. She had a prior commitment from before her
7 appointment.

8 This is the beginning of another year for MedPAC. As
9 always, we will have a full agenda, a mixture of mandated
10 reports, including a couple that we will be discussing at
11 this month's meeting, our usual work, our statutorily
12 mandated work on update factors and the like, a follow-up on
13 past topics of interest like pay for performance and DRG
14 refinement, although much of our work there will not be in
15 public meetings but supporting discussion on the Hill.

16 And then, of course, some new topics as well.

17 Our first topic for today was one that we did touch on
18 briefly last year, valuing services in the physician fee
19 schedule. Kevin, are you going to lead the way on this?

20 DR. HAYES: Yes, thank you. Good morning.

21 Valuing services in the physician fee schedule is an
22 important step in determining the payment rates that are in

1 that fee schedule. Dana will go over details of that in a
2 moment. But we it would be wise first to just briefly recap
3 some points that we made during work on the March and June
4 reports, work on growth in the volume of physician services.
5 This provides some contexts for considering valuing
6 physician services and it also helps explain how this topic
7 fits in with our plan for the upcoming report cycle on
8 payment for physician services.
9 This particular slide is one that Cristina used last
10 year during work on the March report. Recall that it shows
11 growth in the volume of physician services by type of
12 service, major surgical procedures, evaluation and
13 management services, visits and so forth.
14 What we see here is that from 1999 to 2003 volume
15 growth was most rapid with respect to tests and imaging
16 services. These are services that researchers at Dartmouth
17 have described as somewhat discretionary in nature and
18 sensitive to availability and supply. We see the lowest
19 growth for major procedures and evaluation and management
20 services.
21 Recall that following this we received some preliminary
22 information from CMS on spending growth for 2004. The

1 evidence is that these trends continued in 2004 and, if
2 anything, accelerated.
3 So what are the implications of this? On our next
4 slide, we have listed here some concerns that arise when we
5 look at growth in the volume of services, concerns about
6 whether there are perhaps some inaccuracies in the way
7 payment rates are determined. And this is a concern because
8 if payment rates are too high there is the possibility then,
9 of course, that the services have become profitable and that
10 financial considerations are creeping into the decision
11 making process at the expense of the clinical needs of
12 patients.
13 On the other hand, if payment rates are too low, the a
14 concern, of course, is that physicians are unable to meet
15 their costs and, in the extreme, this could give rise to
16 access problems.
17 Taken together, problems of this nature just raise
18 concerns about distortions in the marketplace for physician
19 services and that they could say drive decisions about
20 physician's specialty choice.
21 What do we intend to do on this topic for the coming
22 report cycle? In light of the concerns, what we want to do

1 is in the area of inaccuracies, or what we're calling here
2 mispricing of services, we want to address this topic of
3 valuing physician services. Dana is going to go over in
4 detail our plans for dealing with this.
5 We also intend to address four other topics, adjusting
6 payments geographically, revisiting how the boundaries of
7 payment localities are determined, determining practice
8 expense payments in the fee schedule, and options for
9 changing the unit of payment.
10 The other general area where volume growth becomes
11 important, of course, has to do with the topic of measuring
12 resource use, and that is on the agenda for this afternoon.
13 So let me now turn things over to Dana.
14 MS. KELLEY: MedPAC has long held that Medicare
15 payments should cover the costs efficient providers incur in
16 furnishing care to beneficiaries. Accurate payment is
17 important because it helps ensure them provider decisions
18 are made on the basis of clinical necessity and are not
19 influenced by financial considerations. As Kevin noted,
20 inaccurate payments distort the market for health care
21 services.
22 As you know, Medicare currently pays for physician

1 services under the physician fee schedule using a resource
2 base relative value scale with payment for each service
3 reflecting the relative resources thought needed to provide
4 it.

5 Extensive work was done to establish and validate the
6 physician fee schedule's initial relative values for the
7 work component which encompasses the time, mental effort,
8 technical skill and effort, psychological stress and risk of
9 performing a service. But the amount of work needed to
10 perform a service can change over time.

11 McCall and others at Health Economics Research
12 identified seven factors that can change the amount of work
13 needed to perform a service. These are learning by doing,
14 technology diffusion, technology substitution, substitution
15 of allied health personnel, re-engineering, change in
16 patient severity, and increased documentation. Some of
17 these factors decrease the amount of work required to
18 perform a service which would result in Medicare paying too
19 much for a service unless the value of the service were
20 reduced. Other factors increased the amount of work
21 required to perform a service which would result in Medicare
22 paying too little.

1 Some of these problems are probably self-explanatory
2 but let me run through them quickly. Learning by doing
3 results in efficiency improvements that reduce the amount of
4 work involved in performing a service. As early performers
5 of a service become more familiar with it, they can perform
6 it more quickly and with less mental effort, skill and risk.
7
8 Technology diffusion can increase or decrease the
9 amount of work needed to perform a service. As technology
10 diffuses to more physicians, average procedure time and
11 intensity are affected. Average time and reported work will
12 depend on how familiar providers are with the technology.
13 Technology substitution can reduce the amount of time
14 required to accomplish a task and raise productivity and
15 hourly wage as physician work is replaced by machines.
16 Computerized interpretation of diagnostic tests is an
17 example of this phenomenon.
18 Substitution of allied health personnel for physicians
19 reduces the physicians' time in providing a service.
20 However, it can also have an offsetting effect by raising
21 average intensity per minute for the physician.
22 Re-engineering affects both the level and intensity of

1 physician work by changing the way patient care is managed.
2 An example of Re-engineering is when medical practice is
3 altered so that work flow in a physician's office is
4 changed. When Re-engineering changes the site of care,
5 physician work can increase or decrease.
6 Changes in inpatient severity also affect physician
7 work. Patient severity may decrease as the risk of a
8 procedure declines, making the service a viable option for
9 patients who are less severely ill. Or it may increase, for
10 example, when severely ill patients are considered eligible
11 for a procedure they weren't eligible for before or when
12 changes in clinical practice render a certain service more
13 of a last resort.
14 Finally, the increased documentation required of
15 physicians can increase the work required to perform a
16 service.
17 The Congress thought ensuring accurate payment was
18 important enough to require CMS to review the fee schedules
19 relative values at least every five years. This process is
20 known as the five-year review. The five-year reviews have
21 focused on the work RVUs because until recently only the
22 work RVUs were resource based. The third five-year review,

1 which is currently ongoing, is again focusing on the work
2 RVUs.
3 CMS relies heavily on the assistance of the AMA's RVS
4 Update Committee, or RUC, to conduct the five-year reviews.
5 The RUC comprises 29 members from the medical and health
6 professionals community with 23 appointed by major national
7 medical specialty societies. This slide shows the specialty
8 societies that are currently represented on the RUC.
9 CMS initiates the five-year review process by
10 soliciting comments on potentially mis-valued work RVUs. All
11 of the codes on the fee schedule are open for public
12 comment. Comments are usually submitted by specialty
13 societies. Following review by CMS staff, the suggested
14 codes are forwarded to the RUC for analysis along with other
15 codes that CMS believes also merit review.
16 The RUC operates with the initial assumption that the
17 current relative values are correct. This assumption can be
18 challenged by a society or other organization presenting a
19 compelling argument that the existing values are no longer
20 rational or appropriate for the codes in question. The RUC
21 has a definition of a compelling argument and it consists of
22 such things as documentation in the peer-reviewed medical

1 literature that changes in physician work has occurred or
2 analysis of other data on time and effort measures such as
3 operating room logs.
4 Specialty committees to the RUC conduct surveys of
5 their members, review the results, and prepare their
6 recommendations to the RUC on the codes being evaluated.
7 The RUC may decide to adopt a specialty society's
8 recommendation, refer it back to the society for changes, or
9 modify it before sending it to CMS. Final recommendations
10 must be adopted by a two-thirds majority of the RUC.
11 RUC recommendations are then submitted to CMS, which
12 convenes a meeting of selected carrier medical directors and
13 multi-specialty medical panels to review the RUC
14 recommendations.
15 CMS makes the final decisions regarding relative value
16 revisions but in the past two five-year reviews the agency
17 accepted more than 90 percent of the RUC's recommendations.
18 There are concerns that the five-year review process
19 may not be effective as one might like in revising mis-
20 valued codes. There are a number of problems inherent in
21 the process.
22 The measurement of physician work is subjective. It

1 requires surveys of physicians that include questions about
2 efforts, skill, time and stress associated with a service.
3 Physician input is obviously of the utmost importance but
4 the participation of physicians introduces the possibility
5 of biased reporting, especially since physicians are well
6 aware of the financial implications of the RVU review
7 process.
8 This subjectivity takes on added significance when we
9 recognize that the practice of medicine is highly
10 specialized. In many cases only one specialty furnishes a
11 given service. Thus, that specialty has much influence
12 during the RUC's deliberations and much to gain and lose by
13 RUC decisions. While the review process has some safeguards
14 that help prevent a specialty from dominating the review
15 process, specialization does remain an important issue.
16 A second problem with the five-year review process is
17 the RUC's operating assumption that the RVUs are accurate.
18 RVUs for many relatively new services are almost certainly
19 not accurate. New services entering the physician fee
20 schedule may be assigned relatively high work values because
21 of the additional time, mental effort, risk, et cetera,
22 associated with performing the new service. For such

1 services, we would expect to see physician work go down over
2 time as physicians gain familiarity with the services and
3 become more efficient in providing them. But there's no
4 systematic requirement that recently introduced services be
5 reviewed.

6 A third problem is the strong bias in favor of
7 identifying and correcting undervalued codes. Previous
8 five-year reviews led to substantially more increases than
9 decreases in RVUs. The reviews yielded this result even
10 though the factors that can lead to a service becoming mis-
11 valued -- learning by doing, technology diffusion, et cetera
12 -- suggest that both undervalued and overvalued services are
13 an issue.

14 The bias toward undervalued codes can result in
15 decreased payment for other codes. When more relative
16 values are increased than decreased, the budget neutrality
17 requirement can trigger a reduction in the conversion factor
18 or a re-scaling of the RBRVS. As a result, services whose
19 relative values are not increased can be passively devalued.

20 The resulting mis-valuation can send unintended signals
21 to the marketplace creating incentives not intended by
22 Congress and distorting the market for physician services.

1 As Kevin noted earlier, this distortion in turn may
2 have implications for the distribution of physician
3 specialties. Part of Congress' intent in implementing
4 resource based physician payment was to shift payments
5 towards undervalued services such as evaluation and
6 management but it's not clear that that has happened.
7 For the currently ongoing five-year review, CMS
8 recognized that the process generally elicits comments
9 focused on undervalued codes. So the Agency identified for
10 review services that are valued as being performed in the
11 inpatient setting but that are now predominantly performed
12 in an outpatient setting, suggesting that the work involved
13 in performing the services has changed. CMS also submitted
14 for review services that have not previously been reviewed
15 by the RUC.
16 It remains to be seen whether these criteria will be
17 sufficient to identify overvalued as well as undervalued
18 services. It may be that the process is currently designed
19 as unlikely to yield accurate relative values for all
20 services. The RUC is currently finalizing its RVU
21 recommendations and plans to submit them to CMS on October
22 31. CMS's proposed revisions for work RVUs will be

1 published next spring.

2 For a chapter in the June report, we're planning
3 further work on the process of valuing services in the fee
4 schedule. This will include monitoring the ongoing five-
5 year review so we can assess and comment on whether the
6 process is becoming more successful in identifying both
7 undervalued and overvalued services.

8 We also plan to interview CMS and RUC staff and RUC
9 members, both current and former, to get a better
10 understanding of how the process works and what changes
11 might be necessary. In doing so, we'll explore ways to
12 ensure further review of the RVUs of new services after
13 physicians have gained some familiarity with them and become
14 more efficient in providing them. MedPAC recommendations on
15 this topic could help CMS improve the process for the next
16 five-year review.

17 We also plan to continue the work the Urban Institute
18 did for us earlier on changes in RVUs over time and how
19 those changes interact with growth in the volume of
20 services. We'll be focusing on the effects of RVU change
21 and volume growth on the distribution of payments by service
22 and by specialty. This will help us get at the important

1 question of whether primary care services remain
2 undervalued.
3 That concludes our presentation and we look forward to
4 any comments you may have.
5 MR. HACKBARTH: Thank you, Dana, Kevin.
6 Questions or comments. Ray?
7 DR. STOWERS: I thought it was a really good chapter.
8 I would just make a comment that there was a statement in
9 the chapter about how it may affect distribution of
10 physicians and so forth. I would just like to see that
11 beefed up some.
12 There's a lot of literature out there how this
13 maldistribution of payments is affecting career choices of
14 young physicians and it might be good to reference that. It
15 really does create, as someone mentioned earlier, a really
16 long-term problem of decreasing the number of primary care
17 physicians in the country and therefore eventually affecting
18 the access to care of Medicare beneficiaries and increasing
19 the cost of care in the Medicare system.
20 So I think, considering our audience, we really could
21 get a little more play out of that situation because it
22 really is probably the bottom line seriously thing that's

1 happening here with this maldistribution.

2 DR. NELSON: Part of the problem that I have is that

3 while it's easy to criticize the RUC, it's darn hard to come

4 up with an alternative that has a chance of doing the job a

5 lot better. I'm not very confident that consultants will be

6 insulated from some of these pressures that folks on the RUC

7 themselves are subject to.

8 The RUC does operate on a two-thirds majority rule and

9 that watches out some of the biases. But when I was the CEO

10 for ASIM, I remember the enormous investment that we made as

11 an organization to try to get good data on the work RVUs and

12 surveying enormous numbers of volunteers. And I also

13 remember what a dismal failure the efforts to get precise

14 practice expense data were.

15 One of the things that we need to emphasize in the

16 chapter is that any efforts to get more precise data on

17 either the work value side or the practice expense side is

18 going to cost money and somebody's going to have to do a lot

19 of work. If we're not careful, somebody's going to do the

20 work and get paid for it, whereas in the previous efforts a

21 lot of the work of professionals was voluntary.

22 I guess while I'm a strong believer in the influence

1 that inaccurate pricing has on perverse incentives,
2 nonetheless I'm aware that if you get the pricing exactly
3 accurate today the evidence for inaccuracies aren't going to
4 come for a while, that changes in the way that medicine is
5 practiced is going to create some distortions, just as the
6 transition from inpatient to outpatient created distortions
7 in payment. So it's never going to be perfect because it's
8 a rolling ball game.
9 I think that we need to be measured in our perceived
10 criticism of the RUC if we don't have a darn good idea about
11 an alternative.
12 MR. DURENBERGER: Every time the subject comes up, I'm
13 reminded of the time in 1989 that Rockefeller and I sort of
14 rescued all of this from Lloyd Bentsen, who wanted to let it
15 die. And so I feel at least in part responsible, and I
16 forget that very quickly until we revisit it. And I'm also
17 reminded by Alan's comments of the difficulty of coming up
18 with anything that is perfect. I have two questions or
19 suggestions to make.
20 The reason we did it, and I think this little piece
21 that I've seen that Jack Iglehart wrote in Health Affairs
22 sort of addresses this, that on this sort of charge based

1 reimbursement system as medical technology and other
2 technologies related to the practice of medicine were being
3 introduced in the '70s and in the '80s, the cost of all of
4 that was being passed on to us at the rate of something like
5 14 percent a year. I think that's an average figure that he
6 uses for reimbursement increases. I think there were
7 factors at play. We put the DRGs into effect first without
8 ignoring the fact that we might level off with hospital
9 costs but a lot of things we're going to go shift over onto
10 the physician side and so forth.
11 Having said that, these are the two questions. First,
12 in the sort of premise for impact of inaccurate payments, I
13 would just love to see you add a fourth bullet, inaccurate
14 payments for physician services can -- and this bullet would
15 be harmful to patients' health and safety.
16 That sounds very, very strong I think nobody's going to
17 argue with the fact that overuse, misuse and all these kind
18 of things don't just affect prices and things like that.
19 They have very, very demonstrable and substantial impact on
20 Medicare beneficiaries.
21 And I would love to see us, as we communicate data to
22 policymakers, stress that. Because in our day we didn't

1 know how in the '80s to express that. We didn't know a lot
2 of the things we know today. So I think that's one.
3 The second one, and we may be getting into that a
4 little bit this afternoon, is the analysis of technology's
5 impact on the work factor or the time factor in particular.
6 I have the benefit of teaching in an MBA class a lot of
7 forty-somethings, surgeons and other physicians. And we
8 always come to the question of has the gene pool changed in
9 the last 30 years, so that some of you guys are now worth
10 three times what your fathers were worth -- rarely mothers
11 in the old days, I guess -- but what your fathers were worth
12 back in the '60s or the '70s?
13 Or is it not technology that today enables you to look
14 like miracle workers? Because you can do this noninvasive,
15 you can do all of these marvelous things and you can see
16 what's going on all the time.
17 The point is the importance in addressing this very,
18 very important topic, particularly in the way you've laid it
19 out here, and being able to introduce the consequences or
20 the positive and negative consequences, I guess, of
21 technology's impact on that. And that starts moving us in
22 the direction of productivity and that sort of thing.

1 Thank you.

2 DR. KANE: The meeting brief showed that there was kind
3 of a zero gain in the policy goal of having evaluation and
4 management services sort of gain relative to other types of
5 services in their relative resource investment. I guess one
6 of the questions I have in the process of the RUCs is when
7 you go one by one through these different codes, is there
8 somebody out there at the end who says well, if you do this
9 here's the effect on all of the other codes? Or are these
10 decisions being made one by one without acknowledgment of
11 what that means for all the other codes?

12 It seems at a minimum that the process might be well --
13 especially if there's a two-thirds majority vote that's
14 required -- does everybody understand the systemwide
15 implication of a single change in a work relative value? Or
16 do they just go one by one and not appreciate the broader
17 payment applications?

18 I'm guessing they didn't but that's a question. And if
19 that's true, is there a way to try to build something in a
20 simple model that the staff could build for them, so that as
21 they go through their deliberations they had a better sense
22 that okay, we can up that value, but guess what's going to

1 happen to the rest of us for our evaluation and management
2 codes or whatever?
3 DR. HAYES: As far as I know, but I'm not 100 percent
4 sure of this, there is no ongoing kind of in real-time
5 feedback loop that informs RUC members of what the
6 implications are of raising an RVU for one service and what
7 the implications of that are for all other services.
8 But in the end, when CMS reviews the RUC's
9 recommendations and makes decisions about what RVU changes
10 are to take place, they do that go through a budget
11 neutrality step to readjust everything else so that it all
12 works out in the end. And there are tables of impacts
13 produced in the Federal Register that clearly lay that out
14 by service, by physician specialty and so forth.
15 DR. KANE: But that's after the fact.
16 DR. HAYES: That is after the fact; that is correct.
17 DR. NELSON: They're generally aware.
18 MR. HACKBARTH: I imagine part of the problem also is
19 that the effect of any single change on the overall picture
20 is not very large. It's the cumulative impact over time is
21 where it really starts to be significant. Is that a fair
22 understatement?

1 DR. MILLER: Can I say one other thing on that
2 question, and Kevin I want to make sure this is right.
3 The other reason than E&M looks like it's standing
4 still in the discussion draft that went to you is because
5 some services the opportunity for volume growth exceeds what
6 you can do in those services. So you could be losing ground
7 all through the -- and I don't want to get us off point
8 because we're talking about the physician work, valuation
9 process, at this particular moment. But the other thing
10 that is going on is that you can be losing ground on the
11 basis of volume growth.
12 MR. HACKBARTH: My recollection from Bob Berenson and
13 Steve Zuckerman's presentation was that actually E&M gained
14 a little bit just on the weights, but then they lost more
15 than that through the volume side if you look back over
16 time. Do I remember that correctly?
17 MS. KELLEY: That was the total RVUs that they
18 presented in that slide, not just the work RVUs.
19 MR. HACKBARTH: That's true.
20 DR. REISCHAUER: Just on this last point that we're
21 talking about, it's not at all clear if the world was even
22 more political, as Nancy was suggesting, that the distortion

1 would be less. It might be greater. It would be a
2 different kind. This obviously is very hard to do, and I
3 agree with Alan that it's difficult to think of a markedly
4 different approach that you could argue would come out with
5 a better result.
6 But I think there are mechanisms for incremental
7 improvement, tweaking it. And of course, one of them would
8 be to have a presumptive assumption that learning by doing
9 occurred with each new code that was put in. They do this
10 all the time for manufacturing, engineering, what happens
11 when you're building airplanes and cars and things like that
12 for the first five years you get this curve and then it
13 flattens out. And the burden of proof would have to be on
14 the RUC to say no, that isn't occurring here,
15 notwithstanding the fact that many more people are doing it
16 and the volume is going up.
17 Right now there is sort of a bias that says it doesn't
18 happen and that creates the distortion where we only look
19 for the things that the work units go up in and we don't
20 consider these. And the class where you would find it most
21 frequently occurring is the new, relatively new procedures.
22 I had a question which was whether anybody has ever sat

1 down and looked at comparative information from foreign
2 countries? There are countries that do pay on basically a
3 fee-for-service way, some of the provinces in Canada. It
4 would just be interesting, not necessarily that they're
5 right or anything. But take a handful of these things and
6 see what their relative payments are. And then say look at
7 what we do and see if you can see distortions or how big
8 those distortions would be.
9 You wouldn't be saying one is better or worse than the
10 other. You just say it's different in a lot of what we're
11 in the sense hypothesizing here, we might be able to provide
12 some magnitudes for the amount of change that occurs.
13 DR. HAYES: Just in response, I'm not aware of any
14 comparison like, but we can track that down and see if we
15 can find something.
16 DR. MILSTEIN: This is really continuing Bob's
17 suggestion to staff of tweaks that hopefully might be
18 considered as part of this review, and I'll just go through
19 a few of them briefly.
20 First, last year we had a presentation on cost-
21 effectiveness. And my question is the cost-effectiveness of
22 a particular physician service is not currently one of the

1 criteria that's used in the weighting formula. And maybe to
2 ask staff to give us their thoughts on the degree to which
3 that might be feasible.
4 Secondly, Congress has given us some guidance that they
5 would like us to calibrate payment to American providers
6 based on what efficient providers require, rather than what
7 average providers require. I would also appreciate if staff
8 could look into how that might play itself out in the RUC
9 process. For example, I would imagine when RUC was
10 surveying specialists to find out how long something takes
11 that not everybody is right in the middle. There's a
12 distribution. So it would impact if we began to A, more
13 frequently do those surveys so it's fresher, and B, begin to
14 tilt the formula toward physicians who are more expeditious
15 in the amount of time it takes them to conduct a procedure.
16 MR. HACKBARTH: In Bob's proposal for the presumption
17 of a decline in cost curve over time might also fit under
18 that general rubric, that we're assuming that there were
19 efficiency gains over time.
20 DR. MILSTEIN: Bob's really addresses something that
21 might affect all physicians and mine is, I guess, an
22 embellishment or an addition to that.

1 Last but not least, we heard in the report from the
2 Urban Institute in the last session about some of the
3 understandable biases when people are making judgments about
4 their profession that affect their own incomes. And I
5 think, as Alan has pointed out, that's difficult to get away
6 from if you want to use people who are knowledgeable about
7 the profession to provide your advice.
8 And I'm wondering if we might also ask staff to look at
9 the possibility of using freshly retired specialists to
10 staff the RUC process, who have the knowledge but would not
11 have the conflict of interest.
12 DR. CROSSON: I was going to comment on what Mark
13 commented on a couple of minutes ago, which is I guess an
14 unintended consequence of the RUC process as it relates to
15 the differential increases in volume between E&M services
16 and technology driven services which is laid out a little
17 bit in the paper.
18 I would assume, Dave, when this was discussed 20 years
19 ago that people didn't really realize that differential
20 increases in volume might serve to frustrate the original
21 purpose of this with respect to E&M services.
22 It seems to me again that three of the things that

1 we're working on in this way are interrelated, that is
2 changes in the SGR, the issue of valuation of services and
3 the issue of volume growth. I wondered whether or not we
4 might think about, at least in part, thinking about those
5 three things together at some level.
6 And then more specifically whether or not, you know,
7 there are things to think about in terms of disconnecting or
8 tweaking the valuation process in such a way that it's held
9 harmless to changes in volume. Now I don't know immediately
10 how to do that. But for example, just to start up a little
11 bit, if we were thinking about various changes to the SGR,
12 you could have different SGRs for E&M services and for more
13 technical services which would serve that purpose. There
14 may be other ways to do that.
15 DR. WOLTER: I was going to make the same point Arnie
16 just did. Just philosophically it seems to me that the
17 process would be improved if there were are a panel of
18 experts who were clearly not in conflict of interest and
19 whose own income would not be an affected by the vote, even
20 though the two-thirds majority does create some dilution. I
21 certainly can imagine a better process than this one, and I
22 don't have intimate knowledge of it that Ray and Alan do.

1 However, I have the extremely intimate knowledge of
2 what it's like every year to negotiate with 35 different
3 specialties their particular income. I also know very
4 intimately what all those different specialists annually
5 earn. And that is something that might be somewhat
6 instructive from the Commission. I know we've shied away in
7 the past from looking at information like that, but some
8 understanding of where the specialties lie would be useful.
9 And in that regard, because it's implied in the very
10 excellent material that's been presented this morning, where
11 does the strategic sort of way of looking at what's needed,
12 in terms of the different specialists, where does that fit
13 into this? Because it's not there at all now. It's very
14 focused on the work, the negotiation between specialties
15 about the RVUs. But where is the strategic ability to
16 decide that we need more geriatricians over the next 20
17 years or psychiatrists or internists? I'm hearing we're
18 going to have a tremendous shortage of internal medicine
19 physicians on our hands at a time when we need them badly.
20 So there are some fairly major issues that are not
21 addressed by this process at all. There's a conflict of
22 interest, I think, in the current process. And then the

1 widely disparate incomes I do think are affecting decisions
2 made about where people want to train, in terms of which
3 specialty.
4 I worry about all those things, as well.
5 MR. HACKBARTH: Let me just chime in on that point.
6 Clearly, I agree with your statement, Alan, that we need to
7 be not just critical. We need to be constructive in terms
8 of what we suggest. It's challenging. This is a
9 challenging process.
10 Although, I really agree with what Nick was saying.
11 It's one thing to have a process where people come to the
12 table specifically as representatives of groups affected by
13 the process, as opposed to what we try to accomplish here
14 where people have expertise but we specifically ask them not
15 to come to represent an interest group but to lend their
16 expertise with a focus on the program's broader interests.
17 It's a subtle difference, but I think it can be a
18 critical difference, particularly when played out year after
19 year after year over time.
20 So I think that line of thought, Nick, is very helpful
21 and one we ought to pursue.
22 Ray, did you have an additional comment?

1 DR. STOWERS: Yes. I just wanted to echo what Nick
2 says. I strongly, very strongly, encourage we do go with
3 looking at the overall discrepancy in the income of the
4 different specialties and not just look at individual codes,
5 because that is what affects career decisions and that kind
6 of thing.
7 My second comment comes from being a founding member of
8 the RUC and all of that. It's nice to say that there's a
9 two-thirds majority required for changing a vote but the
10 proceduralists versus the non-proceduralists on there have a
11 two-thirds or more than a two-thirds vote in the process.
12 And I think that needs to be made clear in this chapter.
13 It's not only is there the built-in other bias but those who
14 are dependent upon E&M and cognitive services do not have a
15 one-third vote.
16 So the process is not going to change. It hasn't
17 changed in 15 years. It hasn't made a difference in 15
18 years. And I hate to say that, but unless there's some
19 downward pressure to correct this very severe problem that's
20 going to affect manpower for Medicare and so forth, it's not
21 going to change. So I think this is an opportunity for us
22 to really lay out some of those frustrations in medicine

1 right now.

2 MR. MULLER: I urge us that, in addition to the

3 information we showed on slide two, which shows the growth

4 in the volume of services per beneficiary which breaks it

5 out by the E&M and imaging and so forth, that we add to that

6 the data that we already have on outpatient and ambulatory

7 surgery and so forth. Because I think we've shown in our

8 other analyses the same bias or same disproportionate growth

9 or varied growth is going on there. I think just having

10 those datasets tied together with this would be very helpful

11 to making the case.

12 Because in part of the incentive that we know in our

13 specialty hospital work last year was some kind of sharing,

14 whether one calls it facility or technical revenues and so

15 forth. I think one would see, in addition to what one is

16 seeing within the physician RVUs, one is seeing the same

17 thing obviously on the facility side. That kind of tells

18 the story even in a broader way than even this slide by

19 itself.

20 MR. HACKBARTH: Any others? Okay, thank you.

21 We have now scheduled a public comment period. Because

22 of our late start this morning we have just the one

1 presentation before lunch, so we will have a brief public
2 comment period and then adjourn for launch until one
3 o'clock.
4 Any public comments?
5 MS. McILRATH: I'm the Sharon McIlrath with the AMA.
6 I wanted to make some comments about the RUC and just
7 point out that there are some other things that are involved
8 in setting the values. I know that you guys have looked
9 before at the issue of the GPCIs and the equipment. But
10 whereas this is focusing on the work values, if you look at
11 the practice expense values I think that maybe not everyone
12 understands that what happens there is that the RUC
13 determines what the inputs are, how many minutes of
14 different staff times are used. And then CMS assigns
15 values. And they do that by both pricing the supplies and
16 the clinicians that are used, but they also then have a
17 methodology that is very complicated and that they, in fact,
18 in the proposed rule have said they want to change.
19 And so there are some pricing issues that are
20 introduced through that methodology that also play into
21 this. I Thank you don't want to focus only on what's
22 happening at the RUC. There are a lot of other things that

1 eventually affect all of this.

2 I think you also need to look more at the CMS role. If
3 you look at what they have submitted, in terms of codes to
4 be looked at, I remember that Bob Berenson said in his
5 presentation that it wasn't what they presented. It was
6 that they couldn't defend what they presented. That the RUC
7 has these rules for the level of evidence that has to be
8 compelling that is presented. CMS -- then HCFA -- didn't do
9 that. I think if you looked at what happened this year, you
10 might find a similar sort of thing where the CMS position
11 does not get defended when the values are presented to the
12 work groups.

13 And CMS, it should be understood, is at the table at
14 all of these RUC discussions. So if they had problems with
15 something as it was going through, that would have been
16 discussed, which is one of the things that contributes to
17 the high number of the RUC recommendations that are
18 accepted.

19 In terms of the bias, everybody is aware that it is a
20 fixed pot of money. And if you think that there isn't a lot
21 of fighting at those meetings and that those things are not
22 gone over line by line and critically, I would invite you to

1 attend a RUC meeting. You don't have to be in the same
2 specialty to be able to say, you know, how is this different
3 from this code that I do? Explain to me why you need this
4 many minutes. It can get ugly even.
5 And similar to what happens here, in terms of you're
6 supposed to represent what you think is best for Medicare
7 and its patients, as opposed to whatever special interest
8 you represent, there's a lot of discussion at the RUC about
9 wearing your RUC hat and doing the job that's best for
10 patients, as opposed to what's best for your specialty.
11 And then finally, I just wanted to say that there are
12 some of the things that you all have addressed that the RUC
13 is moving to change, as well, and to look at. One of those
14 is that they're looking at some outside databases to
15 validate the service, the surgical times. In addition to
16 that, earlier this year they looked at the issue of whether
17 you should go back and reduce values on certain things over
18 time.
19 Their approach to that would not be to simply say
20 everything automatically is assumed to have fallen. Their
21 approach would be as you go through the process and you have
22 the discussion initially about a new procedure and a new

1 code to say what would you anticipate would happen with this
2 code? And then create lists of things that need to be
3 relooked at, and possibly sooner than the next five-year
4 review. But if it didn't come up sooner, it then would get
5 reviewed at the next five-year review. It would
6 automatically go on that list.
7 I think Dan is planning to come to the meeting in
8 September and just say that anyone else is welcome to see
9 what actually goes on there.
10 MR. HACKBARTH: Anyone else?
11 We will reconvene at one o'clock.
12 [Whereupon, at 11:59 a.m., the meeting was recessed, to
13 reconvene at 1:00 p.m. this same day.]
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10 AFTERNOON SESSION [1:06 p.m.]
11 MR. HACKBARTH: Okay, our next session is on physician
12 resource use and quality. And if I may, let me just say a
13 word to help set the stage here.
14 You will recall that last year -- and I can't remember
15 if it was in the March report -- we recommended that
16 Medicare began developing the capability to assess patterns
17 of care for physician, develop the tools to do that, and
18 then feed the information back to physicians on a
19 confidential basis, at least as a first step. This is a
20 piece of work that I'm very excited about in that it's an
21 opportunity for us to begin looking not just at how we pay
22 physicians for individual services but broader patterns of

1 care and care crisis episodes in one fashion or another.

2 And then equally important, also potentially over time,

3 begin to link measures of efficiency with measures of

4 quality. If we can successfully do that, I think that this

5 path will be a huge step forward.

6 There's a lot of work obviously to be done to evaluate

7 and actually implement these tools. And on a somewhat

8 separate track at this point, we also have our

9 recommendations moving ahead with pay for performance for

10 physicians as well as for other providers. At some point in

11 the future, the two tracks may merge and this sort of

12 episode thinking with quality measures become the vehicle

13 for pay for performance for physicians. But that may take a

14 while, I don't know how long.

15 I think it's very important and I'm hopeful that there

16 are signs that Congress is prepared to move ahead with the

17 other pay for performance track with physicians. As you

18 know, there are legislative proposals pending to link relief

19 from the SGR formula to the implementation of some pay for

20 performance system for physicians. Obviously we support

21 both ends of that bargain. We have argued that in order to

22 assure access to quality of care, there does need to be some

1 relief from SGR. But at the same time we think that it
2 should be not just more money into the existing system, but
3 one that consistently, in a more focused way, rewards good
4 practice quality of care.
5 So I'm hopeful that we are making progress on that
6 front. And I know with this stellar group in the lead we
7 will make progress on the resource measurement front. So
8 with that little preface, why don't you take over, Anne?
9 MS. MUTTI: This presentation will update you on the
10 work that we're doing on physician resource use measurement
11 and hopefully at the end we'll get your feedback on the
12 direction that we're taking and get your input.
13 As Glenn mentioned, just in setting context, we did
14 have the recommendation in the March report. And then just
15 to say that that recommendation, as well as the research
16 that we're continuing to pursue, really aim at this long-run
17 goal. The long-run goal here is to identify efficient
18 physicians with the thinking that if we can identify those
19 efficient physicians then we can develop policy to encourage
20 greater efficiencies. So that gives it to you in its
21 broadest context.
22 But first we need to be sure that we have valid

1 measures. Because we have defined efficiency as a function
2 of both quality and resource use, we need to have good
3 measures in both those areas.
4 Today, we have three parts to the presentation. I'll
5 be giving you an update as to where we're going on the
6 resource use side. Niall will present some initial findings
7 that we have gained using the software that we'll describe
8 in a moment and also some of our methodological issues.
9 Karen will speak to quality measurement.
10 To just briefly refresh your memories here, we are
11 defining resource use as what Medicare and beneficiaries in
12 the form of coinsurance and deductibles spend on all
13 Medicare covered services. Most of those are provided by
14 physicians or are ordered by physicians. So in a sense,
15 it's a function of price times volume here although we're
16 planning on holding price constant. so we're really looking
17 at volume.
18 We'll be looking an episode grouping software to
19 measure physicians' resource use in caring for fee-for-
20 service Medicare beneficiaries. We find that episodes are
21 an appealing metric, especially for looking at fee-for-
22 service physicians, because they allow us to measure

1 resource use just in terms of the bundle of services that a
2 physician recently cared for, related to a condition and a
3 patient that they recently cared for. At least, that's the
4 theory behind these episode groupers.
5 The software does this grouping by combing through
6 claims data and grouping services related to a common
7 condition like emphysema or hip replacement or diabetes.
8 The episode can then be assigned to a dominant physician,
9 that is one that is determined to be the most responsible
10 for guiding the patient's care. That physicians' average
11 resource use for treating that type of condition can then be
12 compared with that of a peer group.
13 Our analysis is intended to explore further the
14 mechanics and implementation issues associated with using
15 the software with Medicare claims and hopefully identify
16 priorities in using the episode grouper with Medicare
17 claims.
18 So in order to do this I'm going to summarize, we
19 talked about this a little bit in the April meeting last
20 year, but just our reproach for our research.
21 The first analysis we're undertaking, we'll use the
22 grouper software with 5 percent sample of beneficiary

1 claims. The objective here is to get a national perspective
2 on variation using this tool, and also to begin to identify
3 some of these priority areas. For example, if in doing this
4 research we found that certain conditions showed a wide
5 range of variation, certain specialties especially had a
6 wide variation in spending, perhaps that would be an area
7 that we might want to take as a starting point for Medicare,
8 especially if we were particularly confident in our
9 management abilities in those areas.

10 To make his workload a little bit easier, what our plan
11 here is to group all of the claims into episodes first, get
12 a look at what are the most common episodes, what are the
13 most costly episodes, what's the variation in the episodes,
14 and then review our group and pick a subset that we will
15 focus on. We'll also look in identifying that subset to see
16 if there are quality measures available, clinical guidelines
17 that might also help us choose our subset that we'll look
18 at.

19 Once we have this subset we can look at things in even
20 more detail. For a particular condition what is the
21 variation we see and what types of services people are
22 using? What's the variation in the number of doctors who

1 touch that patient in the course of that episode? We can
2 look at some geographic variation too.
3 The second analysis, we'll use the same grouper
4 software with 100 percent of beneficiary claims in select
5 market areas. This allows us to create caseloads for
6 individual physicians because now we'll have this
7 concentration of claims in a given geographic area. And
8 once we get these case loads of episodes for a particular
9 physician, we can begin to look at some of the
10 implementation issues.
11 We've talked about some of these before. They have to
12 do with what is an the minimum sample size of episodes that
13 a physician has to have before they can be accurately
14 measured. What should the outlier policy be? What should
15 the attribution policy be? How do you say what physician
16 was in charge of that episode? How should the peer group be
17 defined? Those are all kinds of things we can look at in
18 this analysis.
19 We plan to do a sensitivity analysis of taking
20 different approaches. What's the impact on the number of
21 physicians we're able to measure? What types of physicians
22 they are? What's the persistence in the scores from year to

1 year, which can be a check on how well the grouper is doing.

2 We selected the market areas that we hope to examine

3 but we can't at this point promise that we will get to all

4 six of them because it's, again, a little bit of a workload

5 issue. They are Phoenix, Orange County, Boston, Miami,

6 Minneapolis, and Greensboro, South Carolina. Our plan here

7 is to come back to you throughout the fall and winter with

8 results of this analysis. We have some primary results

9 today but it's very preliminary and we'll be coming back to

10 you.

11 We decided to use two different groupers in this

12 analysis. We've selected Medstat's MEGs. That stands for

13 episode groups and they're licensed by Medstat, obviously.

14 And also episode treatment groups, ETG, and those are

15 licensed by Symmetry, which is a subsidiary of United

16 Health.

17 ETGs are the market leader, by most accounts, but I

18 think the two, looking at both together will give us an

19 interesting contrast. And so we're looking forward to that.

20 I want to emphasize here though that our goal is to identify

21 the strengths and limitations of the groupers and to figure

22 out maybe what attributes seem to improve the validity. It

1 is in no way any kind of endorsement of a grouper product.
2 We did not do that kind of review, so please don't take our
3 selection in that way.
4 Again, to give you a sense of how we're going to
5 allocate our workload here, our plan is we have actually
6 already contracted with Medstat and they will perform the
7 analysis for us, in close consultation with staff. But they
8 will have the data and run that analysis themselves.
9 For the ETG analysis, we have licensed the software
10 ourselves and plan to do that in-house. In fact, that's a
11 big part of what Niall is going to be doing. To support
12 that work, we have also contacted with a consultant,
13 Integrated Health Care Information Services, also known as
14 IHCIS, and they'll provide us technical assistance in that
15 effort.
16 MR. HACKBARTH: Anne, before you go on, as I understand
17 it, there are three really widely used -- --
18 MS. MUTTI: We have identified three.
19 MR. HACKBARTH: So what I hear you saying is that we've
20 chosen these two not based on some evaluation of which are
21 the best. And we're not doing all three -- and I'm sure
22 there are more than three -- but we're not even doing the

1 three big ones because of resource constraints?

2 MS. MUTTI: Right.

3 MR. HACKBARTH: So rather than spread our effort across

4 all of the available products, we're trying to focus on a

5 couple and do them well.

6 MS. MUTTI: Absolutely.

7 DR. NELSON: Perhaps you're going to get to this, Anne,

8 but are you going to use both grouping software processes on

9 the same physicians and other providers and see whether the

10 outliers identified with one software package comports with

11 that on the second?

12 MS. MUTTI: We plan to do that. In our 100 percent

13 analysis, we'll be able to compare the amount they agree

14 with one another.

15 As I mentioned before, the two groupers offer an

16 interesting contrast and I'll spend the next two slides

17 hopefully illuminating the most significant differences

18 between the two. Here first I'll start with Medstat MEGs.

19 This chart shows how MEGs classify an episode of care

20 and how it adjusts for patient risk, -- that's patient

21 complexity level on this chart -- and the severity level of

22 the disease. The example here is coronary artery disease,

1 for which there is one MEG, and that's out of 557. The
2 average spending for this MEG in this illustration is $3,800
3 and that's noted at the top. This amount can be considered
4 a weighted average, is a weighted average, of the spending
5 reflected in the cells with dollar amounts which are in the
6 lower right-hand quadrant of this table. Really, those
7 cells with the dollar amounts represents break-out of
8 spending for coronary artery disease associated with the two
9 dimensions I just mentioned, severity level and patient
10 complexity.
11 Severity level is on the left-hand side of your table.
12 It's the first two columns there. As you can see in the
13 second column, it is defined on a scale of one to three, and
14 actually four technically because four is death in this
15 case, in their approach. In this example, stable angina is
16 how they define what is in severity level one. It's defined
17 by the diagnosis on the claim.
18 For each of these severity levels, there is also, as
19 you can see across the next several columns, is patient
20 complexity level. That is on a scale of one of five. The
21 patient complexity level reflects -- it's based on the DXCG
22 model that is used in risk adjusting managed care payments

1 in Medicare and it's a function of comorbidities, age and
2 gender. You can see that across the other columns there.
3 So in a sense, you can see here that risk adjustment is
4 built into the grouper. In certain instances there is not a
5 statistical difference in spending between patient
6 complexity levels and then the cells are joined, and you can
7 see that's the case on the bottom row there.
8 The same framework or cell matrix applies to the
9 majority of the 557 MEGs or episode groups. But some it
10 doesn't apply to. Some diseases just don't follow that
11 format. In some cases, there may not be enough specificity
12 in a diagnosis codes to distinguished between severity level
13 one and two or something like that.
14 As you can see, the diagnosis determines severity level
15 that the episode is assigned to. I mention this because
16 this is a significant difference. It does not -- between
17 this grouper and the ETGs, the procedures that was performed
18 does not matter. It does not matter what someone did for
19 that particular diagnosis that goes into that cell. ETGs
20 differ on that dimension.
21 DR. REISCHAUER: When are the determinations made? I
22 mean, at the beginning of the episode, the end of the

1 episode, anywhere in the episode?

2 MS. MUTTI: It's at the end of the episode. For both

3 groupers it's the most serious -- the worst-case part of it.

4

5 ETGs define episodes largely on the basis of the

6 diagnosis and whether a procedure was performed for the

7 given diagnosis. In keeping with our coronary artery

8 disease here, we have how ETG approaches it. They have

9 actually 15 separate ETGs for this particular disease.

10 That's out of a total of 736 ETGs.

11 Here you can see that the definition is dependent on a

12 procedure being performed or not or which procedure was

13 performed. For example, the first two rows here have the

14 same diagnosis but different procedures were done for them.

15 They fall into two different ETGs.

16 So in a sense, the physician's decision to perform the

17 surgery is a proxy for the severity of the disease and the

18 complexity of the patient.

19 Symmetry has also developed super ETGs which join pairs

20 of episodes into one. The pairs they join are those that

21 have the same diagnosis but different procedures, so that

22 you can still look by diagnosis, not specifically by

1 procedure. In this case, then the first two rows would be
2 joined together and the second two rows would be joined
3 together.
4 Not all ETGs are distinguished by surgery. It might
5 not be appropriate. Some might be just the presence of
6 comorbidities or no comorbidities, complications or no
7 complications. For example, there are two emphysema ETGs,
8 one with chronic bronchitis and one without. There's 518
9 super ETGs, if you're keeping score.
10 MR. HACKBARTH: Anne, are you going to talk at all
11 about sort of the underlying thinking? These seem to me to
12 be pretty significant differences in the two approaches.
13 You're depending so heavily on procedures as a way of
14 defining the classes, that begs lots of questions, because
15 that's one of the things that you're trying to get at is how
16 physicians vary in deciding on procedures.
17 DR. MILLER: That's one of the reasons we wanted to do
18 more than one and not completely accidental in how we
19 actually went about choosing that. Some of these have
20 different fundamental ways, so that we wanted to sort
21 through that set of issues in addition to some of the more
22 implementation and mechanical issues. Is that fair?

1 MS. MUTTI: Yes.

2 DR. MILSTEIN: Just to make sure I understand this,
3 just to clarify this point that Glenn just made, the MEGs do
4 not presume that the use or non-use of a procedure implies a
5 different severity of illness. In ETGs there are really two
6 flavors of ETGs. One comes to the same conclusion as the
7 MEG developers and does not assume that a procedure
8 indicated necessarily a more severe illness. The other form
9 of ETG does. And we're going to test both.

10 MS. MUTTI: Right, and we're particularly interested in
11 the super ETGs which collapse the episodes and we would
12 expect to do much of our analysis using those. One thing
13 you lose when you use super ETGs since you've collapsed
14 categories, is less adjustment or recognition of severity
15 level, differences in severity level.

16 DR. KANE: What goes on in the severity level
17 calculation? Does the surgical procedure go into that
18 algorithm?

19 MS. MUTTI: In the MEGs? It's diagnosis driven, yes.

20 DR. KANE: Well, there's one, two and three for the
21 diagnosis.

22 MS. MUTTI: It's a combination of diagnosis and

1 sometimes, if there is a particularly related comorbidity,
2 that will bump you up to your next severity level.
3 DR. KANE: The procedure will never bump you up?
4 MS. MUTTI: But procedure will never bump you up except
5 I think with C-sections, but obviously that doesn't matter
6 here.
7 While how the two groupers define episodes differs, the
8 mechanics of creating an episode is relatively similar.
9 Both draw upon demographic, diagnostic and date of service
10 information from the claims to create episodes of care.
11 Both require a physician or a hospital visit to start an
12 episode. They both tend to look back after an episode is
13 created to see if there were any other sporadic claims
14 related to lab or drug claims that they can then pull into
15 the episode. Both have it so that an episode ends when a
16 clean period is detected. A clean period varies by the
17 episode. It's usually 30 to 60 days, although for chronic
18 conditions it can be a year, so that you can really capture
19 a good length of care there. For both multiple episodes can
20 occur simultaneously. And for both, this gets to the
21 question that Bob asked, the severity level is determined at
22 the end of the episode so that it will be pegged to where

1 the patient was most seriously.

2 This may be the best way to approach it but we should
3 recognize that in the sense it gives the physician the
4 benefit of the doubt to the extent that the patient
5 deteriorates over the course of the episode, that episode
6 will be assigned to a higher cost episode.

7 So in conclusion, I just note that we're on a learning
8 curve here, understanding the logic behind these episodes.
9 So we certainly welcome your questions. Some of them we
10 probably will need to get back to you on. But it would be
11 helpful for us to know what you want to know, the level of
12 detail you want to know, so we can come back with more
13 helpful information in the future.

14 Now I'll turn it to Niall.

15 MR. BRENNAN: Thanks, Anne.

16 Anne has outlined to you the progress that we've made
17 in selecting the grouper software and sites for the 100
18 percent analysis. I'd like to update you all on some of the
19 methodological decisions we've been making, as well as give
20 you a quick overview of our initial experiences in grouping
21 claims using the ETG grouper and some preliminary results
22 from that analysis.

1 As you can imagine, the process of assembling and
2 grouping data for a project such as this is a complex
3 undertaking. First there is the task of assembling multiple
4 large datasets over multiple years while ensuring that key
5 variables are all formatted and named in a similar way.
6 Secondly, we have to make several decisions on exactly who
7 or what we're going to study.

8 We have not included DME or hospice claims in the
9 analysis. Additionally, for the period of our analysis
10 there was no Medicare prescription drug benefit so we don't
11 have any prescription drug claims which both groupers are
12 capable of analyzing.

13 For analytic reasons, we have also excluded any
14 beneficiaries who have one or more months of Medicare
15 Advantage enrollment because we don't have claims
16 information for anyone in a Medicare Advantage plan, and in
17 order to perform an accurate analysis of resource use we
18 need an uninterrupted stream of claims.

19 Another important part of the analysis is the need to
20 standardize payment rates across the various settings we are
21 analyzing. In this way, we can focus on true differences in
22 resource use that are attributable to utilization rates and

1 practice patterns, as opposed to policy driven differences.
2 For example, a community hospital in Montana who treats
3 a patient for stroke will receive a lower inpatient PPS
4 payment than a major teaching hospital in Boston because of
5 differences in the wage index and DSH and IME and GME
6 payments. With this analysis, we want the hospital
7 admission for a stroke in Montana to have a comparable level
8 of resource use to the same hospital admission for stroke in
9 New York.
10 We're also standardizing payment rates in the
11 physician, SNF, outpatient department and home health
12 settings.
13 Over the past few months, we've begun testing the ETG
14 software on a 0.1 percent sample of Medicare claims for
15 calendar years 2001 and 2002. In this way we could test the
16 software on our overall analytic approach while minimizing
17 the amount of processing time needed. We combined hospital
18 inpatient, outpatient, physician, SNF and home health claims
19 for a total of 2.5 million claims over the two-year period.
20 Remember, this is a 0.1 percent sample, so this is
21 equivalent to 250 million claims in the 5 percent sample and
22 2.5 billion claims in the program as a whole over this time

1 period.

2 After running the claims through the ETG software more

3 than 97 percent or 2.4 million claims were successfully

4 grouped into approximately 350,000 episodes. We're

5 currently engaged in a variety of different analyses

6 regarding this grouped data in order to further our

7 understanding of the grouping process and the kinds of

8 analysis we need to perform in order to generate meaningful

9 comparisons of resource use among physicians.

10 Finally, I'd like to present some initial results from

11 this 0.1 percent analysis. It's only one table but

12 hopefully it hints at what's to come. This table presents

13 the 10 ETGs with the greatest amount of aggregate resource

14 use over the two-year period. Looking across the table, let

15 me tell you what's in each column.

16 The first column represents each episode as a percent

17 of all episodes. For example, a chronic renal failure with

18 ESRD represented 0.2 percent of all episodes, a total of

19 $19.5 billion, and an average cost per episode of $36,000,

20 median cost per episode of almost $32,000, and a

21 coefficient of variation of 90.

22 In general, the high resource episodes that we see in

1 this table seem to conform with what we would expect from
2 the Medicare population. Beneficiaries with end-stage renal
3 disease, despite accounting for a small overall share of
4 total episodes, have by far the highest aggregate and
5 average costs with an average cost of $36,000 per chronic
6 renal failure episode.
7 Also included in the top 10 episodes with the highest
8 aggregate resource use are cataract surgery, arthritis,
9 heart disease, prostate cancer, hypertension. And just
10 outside the top 10 are diabetes and a variety of other heart
11 related conditions.
12 The table also gives us a first glimpse of the
13 variation and costs within each episode, which will be one
14 of the factors we consider when we select a subset if
15 conditions for more detailed analysis.
16 Here again, beneficiaries with ESRD provide a good
17 illustrative example. Once a beneficiary is diagnosed with
18 ESRD, the treatment regimen is fairly well-defined with
19 individuals requiring either chronic dialysis or a kidney
20 transplant to stay alive. Therefore, while average costs
21 for ESRD episodes are $36,000, median costs are not much
22 different at $32,000. As a result, the coefficient of

1 variation for ESRD episodes is quite low.

2 In contrast, there is significantly more variation in

3 episodes such as hypertension, diabetes and congestive heart

4 failure, as evidenced by the greater proportional difference

5 between the mean and median costs and the higher coefficient

6 of variation. And obviously, as we progress in our analysis

7 we'll look at all of these a little more closely.

8 I'd be happy to answer questions but first I'm going to

9 turn it over to Karen and she will give you an outline of

10 the quality component to our analysis.

11 MS. MILGATE: We also plan on doing a quality

12 management analysis as a part of this research and we hope

13 to examine several things. First, we hope to look at

14 variation in quality performance and we hope to be able to

15 do this across conditions, regions and to some extent across

16 specialties.

17 We also hope to identify any gaps in quality

18 measurement development that we can. For example, as the

19 chart that Niall just showed, in areas where there may be

20 tremendous variation in resource use, we also might want to

21 look well in fact, are there guidelines in those areas that

22 would better help us understand appropriate resource use

1 levels.

2 We also hope to identify and discuss issues in
3 measuring physician quality. These will be familiar from
4 what Anne said, some of the same issues that you have in
5 looking at resource use for physicians. For example, how do
6 you attribute the care of a particular beneficiary to a
7 specific physician?

8 Also, what are the minimum number of cases you need in
9 order to get a reliable measurement? And the other one is
10 similar as well, peer groups. Who do you actually compare
11 that physician's performance to? What other physicians see
12 similar patients to that physician?

13 And finally, to look to the extent possible at the
14 relationship between resource use and quality. First, is
15 there a relationship, would be one question. Also, we could
16 also identify conditions with variation in resource use
17 where there might also be high variation in quality. So
18 those might become some priority areas for coordination of
19 care, for example.

20 There also may be some ability to identify patterns of
21 service use that are associated with higher quality and
22 lower resource use.

1 Just to be clear, we are not going to be using the
2 indicators that the Commission recommended for pay for
3 performance. That's a pretty easy decision because we don't
4 have that information. But we felt the need to just make
5 that clear because we are working, in this analysis, with
6 data that we already have. What the Commission recommended
7 for pay for performance was to look at IT functionality
8 measures first and then, over a process of two or three
9 years as the data and measures evolve, to be able to then
10 look at condition-specific process measures.
11 For this particular analysis though, we are planning,
12 as I said, to base the quality analysis on currently
13 available information. And for physicians that would be
14 claims data. Again, the limitations of those data are that
15 we have no prescription or lab value data again, again two
16 recommendations the Commission made that if we were to use
17 claims data for pay for performance that we would want those
18 type of data in the claims stream.
19 The set that we intend on using was developed first in
20 1995 for PPRC, one of our predecessor commissions, to
21 monitor ambulatory quality and access. We've recently, over
22 the last two years, undergone a process to revise that list

1 of indicators to reflect the evolution in clinical care as
2 well as the evolution in measure development. So our
3 contractor's done an extensive literature review of clinical
4 guidelines as well as looked at all relevant measure sets to
5 see what types of new measures should be added or measures
6 that might need to be retired from the set we had. We also
7 convened a clinical panel to provide input and then to look
8 at the results of the contractor.

9 The result has been over 35 indicators on conditions of
10 importance to Medicare. Most of them are primarily what
11 we've talked about before as process measures. For example,
12 for beneficiaries with coronary artery disease did they have
13 an annual lipid profile? But they're also a few outcomes
14 measures, one of which is for example for beneficiaries with
15 diabetes what proportion of them ended up in the hospital
16 with short or long-term complications that were related to
17 their diabetic conditions?

18 Many of these indicators are also used by others when
19 measuring physician quality. However, this set was
20 developed specifically for a Medicare population and
21 specifically to be used with this limited claims data only.
22 So that was one of the reasons we decided to use this set.

1 Just to switch just a little bit to say that this
2 analysis, while it will provide the information we described
3 today, also could provide us some information for other
4 projects we're working on such as coordinated care by
5 perhaps identifying some episodes where coordination of care
6 could be really useful for both efficiency and quality.
7 That concludes our presentation today. We look forward
8 to your questions or comments on the analysis.
9 MR. HACKBARTH: So one of the things, Karen, I hear you
10 saying is that using this set of claims-based measures is a
11 very useful analytic tool for us but these are not
12 necessarily the measures that we would want to use in and a
13 pay for performance system?
14 MS. MILGATE: Yes.
15 MR. HACKBARTH: I just want to pound that point home.
16 We're ready for discussion, questions. We'll just go
17 right down, John.
18 MR. BERTKO: First, I'd like to congratulate Anne and
19 Niall and Karen and the team on giving a very good concise
20 definition of this in just a few minutes. Secondly, having
21 run some of these software programs, just let everybody know
22 what a hugely ambitious effort this is, to crunch the full

1 dataset in those six possible sites.

2 Having said that, I've got 100 questions which I'll

3 probably limit to five. The first of which is -- and I

4 don't think you mentioned it, Anne. But there would be some

5 interest at some point, if not in this study, of how stable

6 are these indicators over time? With a two-year dataset you

7 could get some indication. But at some point we might want

8 to come back and revisit that.

9 MS. MUTTI: We do have four years of data and so we

10 could think about -- we have some concerns about

11 standardizing the first year of data. That might be more

12 complicated than it's worth rebut we might able to squeeze

13 three out of what we have.

14 MR. BERTKO: That would be great.

15 The second would be to address something which Karen

16 mentioned, but to say overall in comparison to which peer

17 group? Being a practical guy, I what always suggest that we

18 want to have something we could actually take action on. So

19 it might be specialty within a market, as opposed to the

20 comparison of Minneapolis to Boston. Nice to know but what

21 do we do with it?

22 Thirdly, and this might be for Niall, a question on

1 deaths and the cost of people in their year of death might
2 be fairly complex. I know in a risk adjustment world CMS
3 took one particular solution. I guess I just suggest that
4 you think about that quite a bit.
5 Fourthly, in some of our work we've had trouble with
6 the doctor IDs. And so I would hope that the UPINs for
7 Medicare are all pretty good. But if you haven't run a sort
8 on those in your small sample you might really peer at that
9 before you come up with answers.
10 I guess the last comment, because I was going to limit
11 myself to five, would be to reflect on some things Karen
12 says in the context of the episode measures, which is using
13 only 35 indicators for quality might be good enough for
14 national variation but not within specialty. It would be my
15 guess, not knowing though, that it would be difficult to get
16 good quality measures by specialty in order to fully
17 complement the efficiency measures that Anne and Niall are
18 doing. But just again another guess there. But go for it.
19 MS. MILGATE: We'll certainly see whether we can really
20 meet some threshold requirements. But the conditions are
21 fairly prevalent, so there will be a lot of cell size in
22 terms of beneficiaries. But you're right. And I don't know

1 how many specialties that will necessarily pull believe in.

2 MR. BRENNAN: Those are all good points, John. Just to

3 follow up on the physician UPIN issue, we do know we have

4 physician UPINs on almost all of our physician claims. The

5 ones that don't have UPINs tend to be lab tests and the

6 like. However, we're still exploring the liability of the

7 actual UPINs themselves.

8 MR. BERTKO: Good.

9 MR. HACKBARTH: Before we leave John's list, I think it

10 was the second one about the peer group, in your position,

11 John, trying to build a network for example in a given

12 market using peer groups that are within that market and

13 comparing specialists within a given market makes eminent

14 good sense to me.

15 When you're thinking, though, about the Medicare

16 program and national policy obviously one of the big issues

17 is how patterns of practice vary across markets, not just

18 within markets. And if you have strictly a within market

19 comparison for your peer group you lose that.

20 What your thoughts about John's point?

21 MS. MUTTI: I think our data analysis allows us to look

22 at varying levels of a peer group. That's one of the values

1 of the 5 percent analysis. We'll be able to get a national
2 average so we can compare it on a national basis and then
3 we'll be able to create peer groups at a more local level.
4 MR. BERTKO: Glenn, let me only add that because of
5 just what you said, that this is for Medicare. And if you
6 use it for an educational purpose of might be quite good
7 then to say Minneapolis, in fact, should be the guiding key
8 for cardiac specialties and somewhere else for others and
9 everybody should look towards that, and we should show that.
10 Whether we use it for actual P4P at the individual
11 physician level might be a different question.
12 DR. REISCHAUER: A footnote on that. At the Institute
13 of Medicine panel meeting, some evidence was provided that
14 the range of variation within a geographic area is as large
15 as it is across the country almost. It might be a different
16 levels.
17 DR. NELSON: RWJ has been funding some studies
18 comparing physician profiling systems that if you haven't
19 accessed their work might be informative. They compared one
20 group of five different profiling systems across physicians
21 in an IPA and found that they were essentially non-
22 comparable. But subsequent studies have been done that may

1 be more informative.

2 It appears to me, as a novice in statistics, that the
3 huge difference between median and average costs suggests
4 highly skewed populations which would substantially detract
5 from their usefulness. That is, a physician with two or
6 three high-cost folks in that part of the curve for
7 hypertension would look terrible in comparison with somebody
8 who, by the luck of the draw, didn't have a few high-cost
9 patients.

10 Does that wide coefficient of variation detract from
11 the usefulness of what we're doing?

12 MR. BRENNAN: I guess it depends on the way you look at
13 it. You're right that if there's a big difference between
14 the median and the mean that that means that the
15 distribution can be somewhat skewed. However, both software
16 packages do have sort of processes and methods to deal with
17 outliers. So we can choose to trim the data at specific
18 levels. Like obviously, if most people are clustered around
19 $1,000 and there are three cases that are $15,000 we would
20 probably want to take those three cases that are $15,000 out
21 of the analysis if we think there are good reasons for doing
22 so. The outlier thresholds can be customized for each

1 condition.

2 When you run the data through the first time, it looks
3 at the overall distribution and sort of assigns its own
4 outlier thresholds. But we can also choose to play with
5 those as we see fit. So we will be very careful and
6 cognizant of those issues.

7 DR. NELSON: Also, I presume that their use of risk
8 adjustment and comorbidities and so forth were not included
9 within your preliminary analysis? Am I correct?

10 MR. BRENNAN: That's correct, but again both packages
11 will be able to take into account comorbidities like the
12 complexity levels that Anne showed you on the chart.

13 DR. NELSON: That you didn't necessarily do in this
14 first cut?

15 MR. BRENNAN: No.

16 DR. NELSON: Thank you.

17 DR. MILSTEIN: First of all, I share John's enthusiasm
18 for the focus and the work and the work product so far.
19 Thank you.

20 A couple of suggestions. If the Dartmouth team were
21 here, I think one of the things they might say, the
22 Dartmouth research team at this moment, is that to the

1 degree there's an opportunity -- and I think there is -- to
2 take a look at total cost of care over the course of a whole
3 year for beneficiaries for whom there is an attributable
4 primary care physician, that mode of analysis -- I'll talk
5 in a minute how we might get there with what you've already
6 contracted for -- would begin to create synergies with this
7 morning's discussion.

8 That is if, for example, we were to find that there was
9 quite a bit of -- adjusting as best we can for case-mix and
10 severity -- there were some substantial differences between
11 Medicare's total spending within an area based on
12 differences in primary care physician skill in keeping the
13 patients out of trouble, that would be a way of helping to
14 offset what I'll call the relative weaknesses of the episode
15 approach which is patients incurring multiple episodes. But
16 each episode could be closed efficiently but the question is
17 what about total Medicare spending?

18 That's a question I realize is more pertinent to
19 judging primary care physician performance then to judging
20 specialist performance as a general rule.

21 I think one way that we potentially could get there
22 within the scope of the two groupers that you've selected is

1 potentially through the DXCG grouping capability which is a
2 subpart of MEGs. There is an opportunity to take a -- if
3 you were to so choose to expand the analysis subject to
4 budget capability, it would potentially allow us for a
5 subset of beneficiaries that did have an attributable
6 primary care physician, to also compare primary care
7 physician performance on total Medicare spending over the
8 course of a 24-month period, for example and begin to see
9 opportunities for -- what kind of savings opportunities --
10 it would allow us to model savings opportunities that would
11 directly map back to this morning's discussion.
12 MS. MUTTI: The key there would be that you would be
13 assigning a patient to -- you would be able to attribute a
14 primary care physician for a patient for a full year.
15 DR. MILSTEIN: And run the calculation on total cost of
16 care, not merely the cost of care associated with an episode
17 that had been assigned to a primary care physician,
18 understanding that the way these work is for a chronic
19 illness -- for a particular chronic illness episode, you
20 already made the point, you get a whole year's worth of
21 costs.
22 But from our perspective, it's Medicare total spending.

1 So for example, if two Medicare patients who were otherwise
2 at equal risk, one due to superior primary care physician
3 care, does not have been an AMI episode that gets attributed
4 to a cardiologist, there's opportunities now to bring that
5 AMI back onto the accountability of one primary care
6 physician and actually to the benefit of the primary care
7 physician whose identical risk mix did not incur as many
8 acute MI episodes even though under the episode basis that
9 wide not be mapped back to the primary care physician.
10 I just think one way of leveraging this for our prior
11 discussion would be to run that analysis as well.
12 Before I go on to my second point, let me give you a
13 chance to --
14 MR. BRENNAN: The good thing is that now that the
15 process of assembling these datasets on grouping is almost
16 underway, we have a certain degree of flexibility in the way
17 we look at these things. And while it's possibly, I'm
18 looking at Mark, subject to some staff resource use
19 constraints in terms of our available time, it's certainly
20 possible to look at total costs for a given bene over a
21 given period of time, be it six months or a year.
22 MS. MUTTI: Although we'd have to come up with an

1 attribution rule. That would be the real tricky part, I
2 think.
3 MS. MILGATE: What you think about that? You say
4 clearly attributed, I mean we can decide what clearly
5 attributed would mean.
6 DR. MILSTEIN: Fortunately, there are multiple vendors
7 of software that don't judge episodes but judge total cost
8 of care or 12 or 24 months that have already developed these
9 attribution algorithms, whose help we can get.
10 DR. MILLER: My take on this, and Niall I think I was
11 going down the same road that you were going down, and this
12 is all caveated with we've just entered the field here. And
13 so as we find out how this works. But it would be a process
14 of constructing episodes for sets of beneficiaries. And
15 then say that you pick a specific condition for the purposes
16 of working through this exercise, just for sport, for the
17 moment.
18 Then there's the issue of attribution, which I see us
19 working through in a very iterative way, of kind of going
20 through different ways of looking at numbers of visits a
21 physician might account for or total dollars or whatever the
22 case may be. There's lots of different ways that one could

1 go at that.

2 And I see us coming in front of you and saying there's

3 lots of different ways to go at that, what do you think?

4 And that's, in a sense, an episode type of definition.

5 But it seems to me we are positioned to then look

6 across a year for let's say a condition at sets of episodes

7 and then try and aggregate up. And it would probably

8 involve some differences in the attribution rules, and then

9 come out of that and say okay, this is what it looks when

10 you step up from the episode.

11 The punch line here is I think, with all the caveats of

12 we've just opened this box and we don't know what exactly

13 we're going to find in it, this strikes me as an exercise

14 that's within reach if we put a couple of boundaries on it.

15 DR. MILSTEIN: I agree and I'll pass on my second

16 point.

17 DR. KANE: When you're done doing that, I had another

18 way for you to use your resources that I think might be

19 really important for understanding some of the variability,

20 particularly in some of the conditions like congestive heart

21 failure. I'm concerned that drugs is left out and I'm

22 wondering if at least in one area, even Boston or Miami, if

1 you get the Medigap and the Medicaid files, claims for drug
2 use, and match them? Because I think the variability, even
3 whether they had drug coverage or not.
4 MR. BERTKO: May I defend them in this case? The
5 ability to cross check against UPINs in this, I'll have to
6 say, Nancy, it's an impractical idea. They would come back
7 in two years and say sorry.
8 DR. KANE: Is it possible to go back to the beneficiary
9 ID? I don't know.
10 MR. BERTKO: When you look that's done for the MCBS,
11 where they actually go into medicine cabinets and stuff,
12 they only can do 12,000 people.
13 DR. KANE: I'm just thinking even for a particular
14 condition, would it be worth getting into that level of
15 detail or wait until the drug stuff comes online? Because I
16 think the variability for things like congestive heart
17 failure --
18 DR. REISCHAUER: Take door two, which is wait until
19 next year.
20 DR. MILLER: [off microphone.] I see us hitting the
21 ground, trying to build something of a house here. And
22 then, as the utilization data from the drug benefits come

1 in, we would take another run through this. You can then
2 get to ask interesting analytical questions like does the
3 introduction of the drug have an effect on utilization in
4 other parts of the system? Does it affect your
5 hospitalization, your numbers of physician visits, those
6 types of questions.
7 DR. REISCHAUER: Don't hold your breath for that
8 because we won't have data, I doubt, for the employer-
9 sponsored component of the drug bill. It will just be how
10 much did we give General Motors?
11 DR. KANE: You won't know what their prior drug
12 capability was.
13 DR. REISCHAUER: You won't know what the people are
14 getting because they're not part of the same system.
15 DR. MILSTEIN: Relevant to this point, for private
16 sector purchasers who have begun to use this software to
17 evaluate and compare physician performance, there has
18 already been at least one comparison within a particular
19 geographic area of physician efficiency rankings with and
20 without prescription drug data. And that could at least
21 inform us and staff on the degree to which we might expect
22 to see variation increase, decrease, and/or physician

1 rankings change were prescription drug data to be added.
2 Because I know that that analysis has already been completed
3 by private sector analysts.
4 DR. KANE: I would just encourage us to find out what
5 the implication of the drug benefit, even its presence and
6 then even potentially its actual use.
7 DR. STOWERS: I won't repeat with Arnie said, but he
8 was headed down the path that I am where I think we need to
9 look at the total cost of a beneficiary over a period of
10 time. I'll give a real quick example. A family member just
11 moved from a rural setting with multiple diagnoses,
12 occasional consulate here and there, to a group, a primary
13 care physician, who within six or seven or eight months had
14 made nine referrals to specialists. And all the specialists
15 had done all the appropriate work up for rheumatology,
16 orthopedics, psychological.
17 The bill, within nine or 10 months, was in excess to
18 Medicare of $100,000. I'm not sure how the episode thing --
19 my question is how is it going to pick up on that?
20 Her care has now been transferred back to another
21 physician that's less aggressive in the referral thing
22 because our entire family was tied up taking this person to

1 all of these appointments and so forth.

2 But the point of the matter was there was dramatic
3 difference in resource use and cost to the Medicare program.
4 How does that apply to small group practice versus large
5 group practice, which this was? And those kind of -- and
6 how does that vary, as we over the years looked at the
7 geographic variation in expenditures in some parts of the
8 country in the Medicare program and resource use, as opposed
9 to some of the other states? I'm just trying to get that
10 point across.

11 If we don't get to that, I don't think we're going to
12 get to where the real money is being spent out there.
13 Because if you look at the episodes of all of the specialty
14 visits, they were all appropriate. And all of those
15 episodes. But it was the total episodes and the change in
16 the pattern that was occurring that just put the cost out
17 the roof with this particular patient.

18 The kicker to the story on the quality end is at the
19 end of the $100,000-X-plus, she is on exactly the same
20 medications minus two brand changes that she was on in the
21 small rural practice setting that she came from.

22 So I think we have to somehow get to capturing that

1 type of thing that's happening in the system.

2 MR. HACKBARTH: They're not mutually exclusive.

3 They're both ways of looking --

4 DR. STOWERS: Both have to be done but we've also got

5 to be looking at this other resource utilization in the

6 larger picture.

7 MR. HACKBARTH: When you look at it on an annual or 24-

8 month basis, as you suggested Arnie, how do you compare then

9 the patients. During that period a person with three or

10 four different chronic illnesses, what are the comparison

11 groups when you use these long time intervals, as opposed to

12 episodes where you can say the principal problem for this

13 episode was this?

14 DR. MILSTEIN: It's done, for example, by doing a DXCG

15 analysis on severity of illness for the prior year's period.

16 So going into a one or two-year period what was the person's

17 severity rating? And based on that expected total claims

18 cost going into the year. It's pretty analogous to what's

19 done to set Medicare rates, but in this case using DXCG in a

20 different application.

21 But this is already being done in the private sector

22 and many of the analytical rules have been worked out.

1 DR. STOWERS: I think the point I'm trying to make is
2 looking at one beneficiary over time does not matter until
3 you connect a lot of beneficiaries that are tied to that
4 particular physician. Because as it turns out, in the
5 system which I was a part of, this particular physician does
6 that all the time. For everything that comes in the officer
7 there's a referral. The appropriate work up gets done.
8 So it was a pattern that. And that's where I think we
9 get back to identifying physicians that are higher in
10 resource use. That was the point I was trying to make.
11 MR. BRENNAN: Just in quick response to both your and
12 Arnie's questions, a lot of these episodes are chronic
13 episodes and basically they, de facto, last for a year in
14 length because there needs to be a very significant clean
15 period before you can move on to another episode.
16 so depending on the specific episodes or conditions we
17 select, a lot of them will be de facto full year analyses
18 and some of them will be shorter term, more acute type
19 conditions.
20 DR. MILSTEIN: I think the central point is that if
21 Alan is managing a patient in his practice who starts out
22 the year with chronic cardiac disease and that patient has

1 an acute MI and the primary attributable physician isn't a
2 cardiologist, all the cost associated with that acute MI
3 will not go onto Alan's account.

4 If Alan, for example, if there's another physician in
5 the community who was able to prevent that acute MI, there's
6 no way that an episode-based analysis would be able to give
7 credit to that primary care physician's superior skill in
8 keeping the patient at a lower risk of acute MI.

9 Your point is right and I think Glenn's point is sort
10 of the overarching point, is that both forms of analysis,
11 the episode-based analysis and the year's total cost
12 analysis, are potentially irrelevant to our work. The
13 second is a little bit more relevant to our prior discussion
14 this morning.

15 MR. MULLER: Arnie just anticipated my question, which
16 is since inpatient use is the largest cost category and
17 since oftentimes the inpatient physician is different than
18 the referring physician, normally the case now, how do you
19 do the attribution?

20 MS. MUTTI: We're going to experiment with a number of
21 different attribution rules. You could do something, the
22 physician that has the highest percentage of spending, it

1 could be associated with that person. In that case, for
2 hospitalizations, it may well be associated with the
3 physician caring for that patient in the hospital.
4 MR. MULLER: If Arnie refers them and Ray treats them,
5 how do you do it?
6 MS. MUTTI: You do it associated with the dollars
7 associated with the claims.
8 MR. MULLER: So you go to the beneficiary?
9 MS. MUTTI: Right, the beneficiary.
10 MR. BRENNAN: In the case of somebody who sees a
11 physician and then goes in the hospital, we have a physician
12 claim with a physician UPIN and a hospital claim with a
13 related UPIN. And so there will be dollars associated, the
14 $100 associated with the physician claim and $3,000
15 associated with the hospital claim.
16 Grossly oversimplifying attribution, one of the things
17 is if you attribute episodes based on the frequency with
18 which somebody sees the patient, it will normally go to a
19 primary care physician. But if you attribute them based on
20 dollars, it will normally go to some kind of surgeon or
21 somebody associated with the hospital.
22 MR. MULLER: It's done by the beneficiary.

1 MR. BRENNAN: These are all beneficiary level claims.
2 MS. MUTTI: But we'll experiment with some. some we
3 could just look at E&M visits, who had the greatest
4 proportion of those. And so then you would be looking
5 probably more at your primary care physicians. So our plan
6 is to look at a number of different, five different ways of
7 doing it. That's where we'll look at the number of
8 physicians and the type of physicians who get that episode
9 attributed to them. So we will see what the implications of
10 each approach are.
11 MR. MULLER: I would just assume the dollar volume of
12 any hospital claim will overwhelm 50 or 100 E&M claims.
13 MS. MUTTI: But if you only look at professional
14 visits, then you've got a different calculation.
15 MR. MULLER: So you want the hospital visit -- if
16 you're looking across, that's what you want to get your arm
17 around, not just physician utilization, isn't it? Let me
18 ask John.
19 MR. BERTKO: But the episode has all costs, A and B, to
20 it. But it attributes it to a physician, using one of the
21 rules. So that hospital visit gets attached to the patient,
22 which then gets attributed to that Dr. X, who's the PCP.

1 MR. MULLER: So it's done by the patient closest in
2 time?
3 MR. BERTKO: Yes.
4 DR. SCANLON: I just wanted to add, based upon the
5 discussion I was hearing. I think that we're going to learn
6 a lot from this analysis. And actually Anne and Niall and
7 Karen have been very careful about the caveats and the
8 language that they've been using. I think that's very, very
9 important.
10 And then as our discussion has gone on and we're kind
11 of raising expectation about what we're going to get, we
12 need to remember about the thinness of this data. When we
13 were going through what you sent out, trying to extrapolate
14 per physician what we're going to have in terms of the
15 claims and then thinking about the MEGs, and actually look
16 at that chart that you have which shows the severity levels.
17
18 And the question is is that one episode or is each one
19 of those cells an episode?
20 You can think about well, I can't afford to treat each
21 one as an episode so I'm going to risk adjust to get to a
22 higher level. But there are compromises in that process.

1 And we need to think about that as we're going forward here
2 because this is going to be done in a fishbowl ultimately,
3 in terms of people looking at it. And all of those kinds of
4 adjustments and all the things that we're saying that we
5 have sufficient numbers for are going to be challenged.
6 So again, I compliment them on the careful approach
7 that they've taken in terms of both saying here's the
8 caveats that we need to think about in doing this analysis
9 and we need to continue to apply those as we move forward.
10 MR. HACKBARTH: Okay, thank you. I think that's a
11 reasonable note, Bill, on which to end. We are very much at
12 the beginning of this. Some of the commissioners have much
13 more experience than others of us with it. I'm hopeful, but
14 careful is a good final word on this.
15 Sharon's already there. Next up on the agenda is a
16 mandated study coming out of the MMA on the relationship
17 between home health agency margins and case-mix.
18 MS. CHENG: Today I'm going to present to you the
19 findings of work that we have done in conjunction with
20 Mathematica Policy Research regarding home health agency
21 case-mix and their financial performance as measured by
22 their margins. Your materials included a draft of the

1 report for Congress. Next month you'll see final draft.

2 Up to this point today we've been talking about

3 projects with fairly large horizons. Just to remind you,

4 this is due to Congress December 8th, so a somewhat shorter

5 horizon on this project.

6 As I begin, I'd like to acknowledge the work done by

7 Robert Schmitz, a Senior Fellow at Mathematica who is the

8 lead analyst on our contract with them. And also to

9 acknowledge the considerable thought and effort that Jeff

10 Stensland, my colleague at MedPAC, put into this project as

11 well.

12 The subject at hand is the prospective payment system

13 for home health services and the case-mix system within that

14 PPS. The home health perspective payment system was

15 implemented in October 2000 and it uses a case-mix system to

16 adjust the cost of 60-day episodes for home health services

17 for beneficiaries.

18 This case-mix system groups episodes by the relative

19 severity of patients' conditions and adjusts the payments

20 according to their relative expected costliness. If the

21 system then is working well at the agency level, that

22 agency's case-mix should reflect the relative costliness of

1 the agency's caseload compared to an average agency. and
2 should then distribute payments appropriately.
3 The case-mix system that this PPS uses was developed by
4 Mathematica and Abt and CMS. They were using data from 1997
5 and 1998 to get this online by October 2000. The episode
6 payment that they were designing has to cover 60 days of
7 care and it has to cover all of the home health services
8 within those 60 days. Aid services, skilled nurse, therapy,
9 medical social work, drugs and supplies would be included in
10 the home care bundle.
11 The system uses the patient assessment instrument, the
12 OASIS tool, to measure the status of the patient at the
13 beginning of care and again at the end of care. But the
14 case-mix system is driven primarily from that start of care
15 OASIS. The start of care OASIS measures the clinical
16 severity of the patient, the level of their functional
17 limitation, and also some service utilization. Did they
18 just come from an acute care hospital or a rehab facility?
19 And how much therapy are they going to receive over the next
20 60 days?
21 Each one of those three domains is given a score and
22 then those three scores are put together to determine the

1 case-mix classification. There are 80 groups in the system.
2
3 Once the episode is put into one of those 80 groups,
4 then it has a case-mix weight that is assigned to it and
5 those vary from 0.5 to 2.8. So the weight indicates the
6 relative costliness expected for that episode. So in this
7 system, it ranges from about half as costly as the average
8 episode to nearly three times as costly as the average
9 episode. To use this weight you multiply it by the base
10 rate, you adjust it for local prices, and you get the
11 payment for that episode.
12 Now every year MedPAC considers the base payment and
13 its adequacy. We look at margins and we use those margins
14 and we use our adequacy framework, quality and access to
15 determine whether or not the base payment is correct.
16 What we're today is not so much that base payment but
17 this research asks whether the case-mix is distributing the
18 payments correctly among agencies within this setting.
19 Our mandate was to determine whether systematic
20 differences in payment margins were related to differences
21 in case-mix as measured by the home health resource groups.
22 The mandate instructed us to use cost reports filed by the

1 home health agencies, to which we added claims and patient
2 assessments. And our best full year of complete data then
3 to drive this analysis was 2002, calendar year '02.
4 If there was a strong incentive for the case-mix system
5 to avoid certain patients that could create incentives for
6 agencies to select certain patients and to avoid other
7 types. Over the past several years MedPAC has looked at
8 access to care for home health beneficiaries. We have found
9 consistently that some types of beneficiaries may experience
10 some access problems. However, general speaking,
11 beneficiary access to care for this has been good
12 So at first glance looking at the descriptive
13 statistics, it appeared that in fact agency margins and
14 their average case-mix could be related. When we looked at
15 agencies with the lowest case-mix we found a median margin
16 of 12.3. On the other end of the spectrum agencies with the
17 highest average case-mix had margins on a 22.8.
18 In other words, agencies with the highest case-mix had
19 a median margin that was twice as high as agencies with the
20 lowest case-mix. So if we had only these descriptive
21 statistics, we would probably think that there was a strong
22 relationship between case-mix and financial performance.

1 However, appearances can be deceiving. This cloud of
2 datapoints suggest that the tidy relationship that appeared
3 between case-mix and margin in those simple descriptive
4 statistics is, in fact, anything but tidy. Each point on
5 the graph is one of the 3,400 home health agencies that we
6 had in our sample. The vertical axis is the Medicare
7 margin, which is increasing from bottom to top. And the
8 horizontal access is the average case-mix, which increases
9 from left to right. So if the relationship between these
10 two were strong and simple, you'd expect these dots to march
11 happily from the lower left-hand side to the upper right-
12 hand side. Instead, this cloud suggests that there might be
13 very little relationship between these two factors. Along
14 any horizontal slice you find agencies with the same margin
15 and a wide diversity of case-mix. Slice it the other way,
16 you find the same thing.
17 You might see a little bit of a trend here. The cloud
18 does appear to rise just a little bit from the left to the
19 right.
20 What's making this relationship a little less than
21 tidy? There are a lot of factors that are related to the
22 margin of a home health agency. For example, the type of

1 control. The margins of for-profit agencies are
2 consistently higher than those of voluntary agencies or
3 agencies that are government-based. The rural median margin
4 in 2002 was slightly higher than the urban median margin.
5 And larger agencies tend to have higher margins than smaller
6 ones.
7 Taken all together then, we see that there's more of a
8 web of relationships than a nice straight line. What these
9 descriptive statistics then suggested is that we had to up
10 our statistical power a little bit. I was going to move to
11 the model.
12 MR. HACKBARTH: Just to help me stay oriented, if the
13 case-mix system was working perfectly, you would hope to see
14 that there was no relationship between margin and case-mix.
15 So the fact that there is a cloud --
16 DR. REISCHAUER: After you've controlled for everything
17 else.
18 MS. CHENG: All else equal, right.
19 DR. REISCHAUER: But we haven't controlled for
20 anything, at this point. She's confusing us with her cloud.
21 MR. HACKBARTH: You're way ahead of me, as usual.
22 So my simple-minded thinking is after you control for

1 appropriate variables you would hope that there would not be
2 a relationship between margin and case-mix.
3 Now if we were looking at cost in case-mix, there you
4 would hope to see a nice clear pattern showing that there's
5 a close relationship, controlling for other things, right?
6 So the fact that Congress mandated that we look at margin,
7 the relationship between margin and case-mix is important in
8 terms of the sort of picture we want to see up here; right?
9 MS. CHENG: Right.
10 MR. HACKBARTH: The other thing that struck me was that
11 efficiency was nowhere on this list of other factors related
12 to margin.
13 MS. CHENG: Which would absolutely be part of it.
14 DR. SCANLON: I guess there's a different question, I
15 think, that could have been asked which apparently the
16 Congress didn't, which is the issue of the relationship
17 between the case-mix measure and the costs for individual
18 patients, where you would be aggregating across one of these
19 HHRG groups, as opposed to looking at what's happening with
20 the agencies. Because the agency effect is one of the
21 averaging. Does an agency specialize?
22 Because your example of higher case-mix index and

1 higher cost, in order to see that when you're looking at an
2 agency set of data, you've got to have agencies who
3 specialize in high cost and agencies that specialize in low
4 cost. Otherwise, you could get a datapoint in the center.
5 There is another question which I think is still
6 potentially relevant and I was going to ask about it later,
7 which is the issue of what's happening within HHRGs in terms
8 of relative profitability.
9 MS. CHENG: We did build the model more strictly
10 sticking to the mandate, which is to try to see what we
11 could find out about the relationship of case-mix and
12 financial performance and margin. What we have then is a
13 multivariate model of financial performance. Again, ideally
14 the case-mix should predict differences in costs and then,
15 all else equal, should have no impact on financial
16 performance.
17 We found that our best model with all the factors that
18 we have up here, case-mix, rural/urban location, type of
19 control -- and that's government, voluntary and for-profit -
20 - volume, which is our proxy for the size of the agency. We
21 also used the nine census regions to get a flavor of
22 geographic variation.

1 When we put all of those factors together, we were able
2 to predict almost none of the variation in financial
3 performance. The R-squared value on this model indicates
4 that about 5 percent of the variation in margin is explained
5 by all the factors you see on this table. The coefficients
6 on these factors give you a sense of the size of the effect
7 of each of these factors on our dependent variable. The
8 dependent variable here is the log of the payment-to-cost
9 ratio.
10 In other words, the coefficient on our case-mix factor
11 suggests that a 1 percent increase in the agency's case-mix
12 score would result in 0.2 percent increase in the payment-
13 to-cost ratio.
14 Overall, the model's outcome suggests that we really do
15 not know what determines the financial performance of home
16 health agencies under the PPS. But it also yields a
17 parameter estimate on the case-mix measure that is positive
18 and, as you can see here, also turned out to be
19 statistically significant.
20 Finding this kind of estimate in a weak model is still
21 a slight concern because it implies that while the model
22 does a poor job of predicting financial performance, it does

1 appear that there is a relationship between case-mix and
2 financial performance. It implies that agencies with higher
3 case-mix, all else equal, will still have somewhat higher
4 margins.
5 The result of this model of financial performance is
6 not entirely surprising. Financial performance is difficult
7 to measure, let alone to predict. And even to do so in a
8 fairly mature setting such as an inpatient hospital where
9 all of the factors have been thoroughly studied, we are
10 dealing with a five-year-old payment system here which I
11 wouldn't quite describe yet as mature.
12 Financial performance for any provider would also be
13 related to many factors that we have not included in our
14 model. Dr. Scanlon suggested efficiency. There would be
15 management. There would be the relative competitiveness of
16 the market in which that home health agency were operating.
17 To meet the objective of this report we were not trying to
18 build a fully specified model of financial performance. We
19 were really trying to get at what we could learn about the
20 relationship of case-mix and financial performance.
21 We did develop this basic model one stage further.
22 What we tried to do was look at some patient characteristics

1 that we could measure from our OASIS start of care
2 measurements but that aren't included in the case-mix. So
3 we had some measures of things like whether or not there was
4 an informal caregiver in the home that would be able to
5 supplement the paid care from the home health agency. We
6 also looked at whether a patient had severe functional
7 limitations.

8 However, when we added those patient characteristics to
9 our model they did not tend to turn out statistically
10 significant and we did not boost the ability of the model to
11 predict variation at all. We stayed at an R-squared of just
12 about 0.05.

13 The conclusion then that we reached from this research
14 is that our model's ability to predict financial performance
15 is weak. However, the positive relationship between case-
16 mix and financial performance indicates the need for further
17 analysis.

18 What I'd like to get from you this afternoon would be
19 your reactions to this conclusion and the content and tone
20 of the report that we are going to send to Congress.

21 While I've got you, I'd also like to say that I think
22 that this research fits well into the continuing work that

1 we're doing in this payment sector. We would like to seek
2 to understand the costs at the episode level and we'd like
3 to do a fair bit of research on that. And we'd like that to
4 feed into more general work to assess some ideas to refine
5 the PPS.
6 Do we need better categories of patients? Do we need
7 to reweight the categories that we have? do we need to look
8 at other aspects of the payment system, outlier, therapy
9 threshold, et cetera? So I see this as an organic part of
10 what we're doing in home health generally.
11 DR. STOWERS: For fear that Mary would come back to
12 haunt me, I just had a question. On the rural, in 2002
13 there was an enhanced payment for rural home health care
14 which I think has been removed now. Have we corrected for
15 that, if we're really thinking about where we go in the
16 future? Or how does that play into this? Since we're
17 talking margins, I guess is what I'm talking about.
18 MS. CHENG: I didn't correct for it but there was a 10
19 percent add-on payment for taking care of beneficiaries who
20 are in rural areas. That's a market that is dominated but
21 not exclusive to agencies with a rural location. But the
22 fact that the median rural margin was higher than the urban

1 one, I would attribute largely to the add-on payment that
2 was in place at the time.
3 DR. STOWERS: But since that's not there now and we're
4 kind of looking at where we go the future it might be
5 something we could make a comment about or take into account
6 on that.
7 MS. CHENG: When we look forward, we model the impact
8 of the removal of that, yes.
9 DR. STOWERS: Okay.
10 MR. MULLER: My statistics courses are a long time ago
11 so I'm going to expose some ignorance year. But those
12 coefficients are all pretty low. So remind me, you really
13 feel comfortable with that conclusion, the econometricians
14 on the staff and so on, that those low coefficients and that
15 low R-squared?
16 DR. MILLER: Let me take this one. We had lots of
17 conversations internally about what we thought we were
18 looking at here. Remember that the specification of the
19 model -- and that's an advance word there -- but what we
20 were looking at is driven by what the mandate is.
21 I don't think any of us are surprised that the analysis
22 in running these models doesn't explain the financial

1 performance. I think explaining financial performance is
2 really hard. You could enter another 50 variables and still
3 probably not get very far on this.
4 Nonetheless, having said that, we were a little bit
5 disturbed by the fact that you do have any relationship
6 between case-mix. Now it's in the context of a model that's
7 not doing particularly well but it's still bothersome.
8 I think Sharon said it well, our point is we're five
9 years into this prospective payment system. We've been
10 systematically, and the commissioners have been
11 systematically raising issues about what about the
12 distribution of this system? We think this is just another
13 piece, and probably not a great piece, but a piece of that
14 puzzle that says the time is now to start looking at the
15 structure of the system.
16 MR. HACKBARTH: Like you, Ralph, I feel totally
17 uncomfortable with my grasp of the statistics. But looking
18 at this as a lawyer, to me that's not a very powerful
19 resounding conclusion.
20 Based on other things that we've done previous to this,
21 I think we're a little anxious about whether this system is
22 appropriately allocating the dollars, just anecdotally. So

1 aside the statistical analysis. So all we're saying is
2 further analysis is our conclusion is that we need to study
3 this.
4 MR. MULLER: Let me ask this more in kind of patient
5 terms. What Carol always reminded us of was the high acuity
6 complex patient -- and we had the same experience in our
7 home care agency. You think there's reasonably high margins
8 on infusion therapy and there's very low to negative margins
9 on the highly complex patients.
10 How well does the case-mix system capture at least
11 those two sets of patients? The very complex patient who
12 may just have difficulties with activities of daily living
13 but maybe not any major medical needs. And then, at the
14 other end, the infusion therapy patient. How well does the
15 case-mix system, do we think, capture those two sets of
16 patients?
17 MS. CHENG: The work that we've done here is really
18 tried to look at costs at the agency level. So each of my
19 observations are the total cost for the agency. I think
20 that the next step ought to be to look at costs at the
21 episode level. And to do that, we need to be able to
22 allocate costs. Right now all I had to do was allocate the

1 cost to the agency to the agency.

2 To look at the costs per episode, I'm going to have to

3 be able to get inside that episode and figure out what the

4 agency's costs were to produce that episode. And that's a

5 different level of analysis than we've pursued here. I

6 think it's the way that we need to go. But I don't think it

7 pulls directly into responding to the mandate up on the

8 agency level.

9 DR. MILLER: Can I just pick up for a second? I think

10 what you're pointing to is whether -- and I'll stop. But

11 what you're pointing to is a direction that I think we need

12 to go down.

13 You could have a situation here where you construct the

14 PPS on obviously pre-PPS data by definition. You construct

15 these episodes. What could be explaining some of this is

16 that it turns out that the episodes at the high-end of the

17 HHRGs created the greatest opportunity for profitability if

18 you've changed the underlying service mix, if you lowered

19 the visits for those types of patients. And I think the

20 $64,000 question is yours, okay for the kinds of patients,

21 how did they fall across those HHRG categories?

22 And in answer to at least some of your question, there

1 are definitely characteristics that you're referring to that
2 are not captured by the HHRGs. So the question will be how
3 the patients fell across the HHRG categories.
4 MR. MULLER: The supposition, and again Carol is the
5 one who's most articulate on this, is you have these
6 patients that may have a lot of multi-system failure but no
7 immediate medical need that day but they need a lot of
8 visits and a lot of care just because they just don't
9 function very well. But no particular things of high acuity
10 that therefore gets them high case weight.
11 So you can see those patients as requiring just a lot
12 of time and visits and having negative margins because it's
13 a low payment but a lot of visits and care. So you would
14 think on those patients you just lose a lot. That's the way
15 Carol always told us that her population base was low to 1
16 percent margin and not complex as measured by the case-mix
17 system but very resource consumptive.
18 If the case-mix system doesn't capture resource inputs
19 very well on that kind of population, and that's generally
20 true in the DRG system as well, on the kind of medically
21 complex patients versus the surgical patients. That's a
22 point we've made in general in other payment systems, as

1 well.

2 MR. HACKBARTH: In a way here, the question being asked
3 is perhaps not the right one. I don't mean that in a
4 critical way but I don't want to feel too constrained by how
5 they ask the question, how they framed the question.

6 So the report we submit, and I know we're on a very
7 short time schedule and won't maybe be able to do all of the
8 analysis we would like to do. I would like the message to
9 be this analysis was weak. It doesn't support a lot of
10 conclusions. But based on other work we have done, we have
11 real concerns about how well this system is functioning in
12 allocating the dollars across patients.

13 MR. MULLER: For example, the so-called cloud. In our
14 other payment systems we don't have a lot of plus-80s and
15 plus-70 percent margins or minus-70s and minus-80s. But you
16 had quite a few datapoints at the plus-50, plus-60 and plus-
17 70, and interesting enough some datapoints at minus-100,
18 which is an interesting operation to run.

19 I was impressed by just how many datapoints were above
20 the plus-35 or 40 percent level because when we looked at
21 the specialty hospital study we were kind of shocked at some
22 of those 20 or 30 percent margins. Here you have quite a

1 few built into the overall agency margin.

2 MS. CHENG: We've certainly made the observation before
3 that the hallmark of home health is variability. As you
4 recall, we left the last cycle looking at the outlier
5 payment. And one of the exercises that we did was to look
6 at the minutes per episode by HHRG. So we did break that
7 down into the episode type.

8 And for more than half of the 80 groups we had a
9 coefficient of variation from agency to agency for the same
10 home health group of greater than one. So at one agency you
11 could get almost nothing and at another agency you could get
12 twice the average number of minutes of care within that
13 episode. It's a very highly variable service and that's
14 definitely what's showing up in this analysis.

15 MR. HACKBARTH: And there's huge range among the
16 providers from Carol's VNA to these little tiny
17 organizations.

18 We need to move ahead.

19 DR. MILSTEIN: Your comment answered my question.

20 MR. BERTKO: Just a quick one. I seem to recall but
21 I'm not sure that home health was one of the service sectors
22 that jumped or dropped precipitously after the BBA, after

1 this went in and then came back up. It sounds like I've
2 recalled it correctly. To add to Glenn's caveats here, and
3 your statement Sharon that it's maybe not mature, might even
4 2002 data not be ready yet? Or the right dataset to do this
5 question?
6 First of all, we don't have a good conclusion. But
7 secondly, we may have to really say you should wait a while
8 before you draw a conclusion.
9 MS. CHENG: We could certainly look at what 2002 is
10 telling us. One of the things that we have tried to measure
11 is the average number of visits per episode. I noted that
12 this case-mix system is built on '97-'98 data when the
13 average number of visits per episode was up around 36 or 38.
14 What we have measured since the inception of the PPS is an
15 average visit per episode that stayed right around 19. The
16 big change that absolutely occurred occurred during the IPS,
17 that interim payment system, that was put in place between
18 the cost base and the fully prospective payment system.
19 And since then the average number of visits per episode
20 hasn't changed dramatically. So I think 2002 probably looks
21 a lot like 2003 and 2004.
22 DR. KANE: [off microphone.] Is this overall agency

1 Medicare payments to overall agency Medicare costs? It's
2 payment to cost ratio, but is it the total at the agency
3 level of payments to total Medicare costs? It looks like
4 some of these agencies have a lot of costs but aren't doing
5 any business yet and that's how you get a minus-90 percent
6 margin. So it's not a unit? These are not unit payment to
7 cost ratios, this is the whole agency Medicare to total
8 costs. And they could just not have any payments because
9 their volume is way off. Is there a way to do some sort of
10 a --

11 DR. REISCHAUER: These are freestanding, right? This
12 isn't hospital-based at all?

13 MS. CHENG: We've excluded the hospital base from this
14 analysis. They did have to do a minimum number of episodes
15 to get into the dataset but some of these agencies, in fact
16 a quarter of them, provided 150 episodes or fewer in our
17 year. So some are pretty small.

18 DR. KANE: [off microphone.] It would be useful to get
19 rid of some of the ones that would be very low volume. You
20 can't have a minus-100 profit margin unless you have a lot
21 of costs and no revenue.

22 MR. SMITH: I'm plowing ground that others have plowed,

1 so I'll be very brief.

2 It strikes me that some of Ralph's discomfort with the
3 conclusion, which I share, has to do with the question. We
4 might want to reframe the conclusion, Sharon, to say that we
5 were unable to establish a relationship between case-mix and
6 margin, but we uncovered a lot of other interesting
7 questions which warrant further analysis. Saying that we
8 want further analysis on the relationship between case-mix
9 and margin doesn't seem to me to be either very important or
10 what's indicated by the mailed material.

11 DR. SCANLON: I would just agree. I think that the
12 question that's important is the episode analysis that
13 you're planning on doing. And that's really where we should
14 be focusing in the future. And also. I think, trying to
15 soften the results that we've got, saying that there hasn't
16 been enough time and the response isn't mature yet is
17 potentially an overstatement.

18 Within the home health industry, the changes in
19 response to policies have been so dramatic. And your
20 response to John that you think that 2003 and 2004 will be
21 somewhat similar to 2002, I think the transition has already
22 occurred for the agencies that exist today.

1 The transition that we haven't seen yet, which we're
2 starting to see now, is the emergence of more agencies
3 coming back into the business. That was that big change
4 after the BBA was all kinds of agencies that had come in
5 rapidly left rapidly. I think now when you see 15 percent
6 average margin potential for 30, 40, 50 percent margin
7 you're going to start to attract newcomers.
8 We still don't have any barriers in terms of people
9 coming into this business.
10 That's the kind of change I think, and I'm not sure
11 that it really applies to this analysis here as much. So I
12 would kind of downplay that in the report that we've got.
13 DR. CROSSON: I just wanted to follow up on what Nancy
14 said, and I was somewhat emboldened by it because, as with
15 Ralph and you, it's been awhile since I've done statistics.
16 But as long as you've offered a lawyer's version of the
17 statistics, I thought maybe a physician's one.
18 Could you put the scattergram back?
19 It just struck me when I looked at that that it's kind
20 of hard to understand all of those negative margins, and
21 particularly the robustness of some of the negative margins.
22

1 I just wondered, because if I look at it and I just
2 block out the negative margins for a minute, you actually do
3 begin, in the main body of it, you do begin to see more of a
4 correlation than if you try to take the whole scattergram in
5 at one time.
6 So what I'm wondering is -- what I'm saying is if you
7 block out the bottom half, right?
8 DR. REISCHAUER: The clouds on the horizon.
9 DR. CROSSON: I guess what I'm saying is before we
10 write it off as as weak as it appears to be, is there any
11 reason -- as Nancy was saying -- to maybe take another look
12 at it and ask ourselves some questions about whether some of
13 the outliers, particularly on the negative side, ought to be
14 moved out of the analysis and try to do another statistical
15 analysis on some theoretical basis that kind of looks at the
16 main body for those that are making money, that appear to be
17 more substantive or something like that?
18 DR. MILLER: [off microphone] There could be an
19 argument like that. And remember that a lot of this is
20 driven through a logged model which helps compress -- this
21 is just a scatterplot put up there. Logging helps put some
22 of that variance and helping track more. But your point is

1 still taken.

2 The only thing I would say is that if you go into this
3 and trim the data, I don't think it would be particularly
4 that you go in and say okay let's take out all of the
5 negative. You would set some trimming rule that would hit
6 both the top and bottom. So I'm going to take out anything
7 with margins that are greater than or lesser than and hit it
8 on both sides. Because otherwise then you're just pulling
9 out part of the relationship in that example.

10 The last thing I would say is you are right, and we
11 also, in speculating about this Rorschach test and that type
12 of thing. Yes, there is something of an upward trend. But
13 even in that block that you're looking at, that has
14 something, look at the variation around it. And so that
15 also will kind of weaken the relationship. And why I don't
16 think it's really surprising that the parameter, even though
17 positive, isn't coming in really strong. But that's all a
18 long way around of saying yes, we can certainly go through
19 and troll through this data and parse it out a little bit
20 further and look at the relationship.

21 DR. REISCHAUER: But you think it's not a particularly
22 good question to find the answer to. So why are we

1 struggling to find the better answer to a bad question?

2 DR. CROSSON: Because that's what's Congress asked for.

3 DR. STOWERS: Speaking of what Congress asked for,

4 because this was a mandated report, I remember the argument

5 on the Hill at the time being the fact that there was high

6 profit margins in the home health care agencies that were

7 focusing on physical therapy and rehab, post-surgical, as

8 opposed to those taking care of multiple diagnosis

9 chronically ill patients. And I'm not trying to be non-

10 scientific but is this report answering that question?

11 DR. MILLER: In a sense, and I'm going to try to pull a

12 couple of threads together, that's the upper half of Ralph's

13 question earlier about agencies at the bottom end of the

14 distribution having to deal with the extensive care patients

15 at the upper end. This is why I think Sharon's point and I

16 think Bill's point of that you need to go inside the episode

17 to see what's going on.

18 One way that you could explain some of these results is

19 that at the upper end those HHRGs created a greater

20 opportunity for profit. So let's just say for sport -- and

21 this is now just speculation. We're talking about therapy

22 patients here. You take relatively functional therapy

1 patients and you reduce the number of visits that you're
2 providing. And you have created a great profit opportunity,
3 even though the HHRG for that patient is quite high.
4 I think that's the kind of stuff where I you have to
5 really get in and unpack episode by episode what is
6 happening to the patients.
7 DR. STOWERS: Because their question was do we need to
8 redistribute those funds.
9 MR. HACKBARTH: Anybody else on this one?
10 Thank you, Sharon.
11 Next is Carol presenting on growth in spending for
12 outpatient therapy.
13 MS. CARTER: Spending on outpatient therapy services
14 has grown considerably in the recent past. According to
15 CMS's contractor, spending increased 60 percent between 2000
16 and 2002. CMS noted that growth in outpatient therapy
17 services was a key contributor to physician fee scheduling
18 spending increases during 2003.
19 These spending increases raised several questions for
20 Medicare. What is the program buying for these increased
21 expenditures? Has spending increased more rapidly for some
22 patients, settings or providers, certain types of cases?

1 Are beneficiaries receiving more services? And if so, are
2 the services medically necessary?
3 In addition to concerns about the value of services
4 furnished, the reimposition of the therapy caps this coming
5 January have some policy analysts concerned about whether
6 the limits are the best way to target Medicare spending.
7 Today I'll present background information about
8 outpatient therapy services, and then discuss the therapy
9 caps. Staff is seeking commission feedback on the analysis
10 and information it will want to have as it explores policy
11 options.
12 Just as background, outpatient therapy services
13 includes physical therapy, occupational therapy and speech
14 and language pathology services. About 8 percent of
15 beneficiaries use outpatient therapy services and the
16 spending totalled $3.4 billion in 2002. Three-quarters of
17 that spending was on physical therapy services.
18 Now I'd like to set the stage a little bit for some of
19 the data limitations that we will encounter over the coming
20 year. The diagnosis information on outpatient therapy
21 claims is poor. Institutions are not required to submit
22 specific diagnoses on their therapy claims and diagnoses is

1 often actually a service. Thus, for example, the most
2 common diagnosis for PT services on claims is other physical
3 therapy. The diagnosis on claims are often vague and can
4 sometimes describe the location of pain, such as shoulder
5 pain, or pain in a joint or limb.
6 Another problem with the diagnosis coding is that
7 although a single claim may include more than one type of
8 therapy furnished during a visit, providers are not required
9 to list separate diagnosis for each service rendered. As a
10 result, diagnosis associated with occupational therapy and
11 speech and language pathology services are likely to more
12 properly describe the physical therapy services that they
13 may also be receiving. So for example, abnormality of gait
14 is a common diagnosis for beneficiaries receiving speech and
15 language pathology services.
16 With these limitations in mind, six of the 10 top
17 diagnoses for patients receiving physical therapy were
18 musculoskeletal related. Among OT users stroke was the most
19 common diagnosis, and swallowing disorders were the most
20 common disorders for speech and language pathology service
21 users.
22 Here is a pie chart of who provides therapy services.

1 This is based on dollars, but it would look very similar for
2 patients. The largest is skilled nursing facilities,
3 followed by hospital outpatient departments. SNFs furnish
4 outpatient services in two ways; to SNF residents who do not
5 qualify for a Part A stay but can still have their therapy
6 paid for under Part B, and they provide some outpatient
7 therapy to beneficiaries who come to receive outpatient
8 therapy.

9 While services are provided in many different settings
10 they are all paid under the physician fee schedule
11 regardless of where they're furnished. Prior to 1999, the
12 institutional providers were paid on a cost basis, but in
13 1999 their payments were shifted to the physician fee
14 schedule.

15 Now I want to just go over briefly the therapy caps.
16 Two spending limits were implemented as part of the BBA.
17 All providers of outpatient therapy except hospital
18 outpatient departments were subject to two limits. There is
19 a $1,500 limit on PT and speech and language pathology
20 services combined, and a separate $1,500 limit on outpatient
21 therapy services. These limits are updated for inflation.
22 The therapy caps were operations in 1999, but since then

1 moratoriums that lifted the limits have mostly been in
2 place. The current moratorium is due to expire at the end
3 of this year with the caps scheduled to be reimposed in
4 January.
5 Here is what's been happening with changes in spending
6 and user. While the caps were in place, and that's in 1999,
7 you can see that spending was curtailed. This was in part
8 due to the therapy caps and in part due to other policies
9 that were implemented that year, such as when all the
10 institutional providers moved to the physician fee schedule,
11 and another factor was the implementation of the SNF PPS.
12 That precluded SNFs from separately billing for outpatient
13 therapy services for the Part A stay patients.
14 You can see that between 2000 and 2002 aggregate
15 spending increased quite a bit. That's the 60 percent I
16 mentioned before. This is a result of both more users and
17 more spending per user.
18 Another factor that I wanted to go over because I think
19 it will color a little bit the kinds of analysis we do over
20 the year is just to begin to describe some of the variation
21 in per-user spending. Here I've looked at three different
22 types, diagnoses, settings, and states. You can see that

1 there's generally at least a two, if not three or fourfold
2 variation, between low and high end spending per user. At
3 the far left I've compared average per-user spending for
4 patients with back pain and stroke and you see over a
5 twofold variation there. In general, the more common
6 diagnoses are the less expensive to treat.
7 In the middle I've compared a low-cost setting,
8 physicians' offices, with the highest cost setting which are
9 comprehensive outpatient rehab facilities. You can see a
10 very large difference there. It's about twofold again.
11 And then the last pair that I've showed is a low-cost
12 state and a high-cost state. I'm sorry, the color didn't
13 come out that well but it's about a fourfold variation there
14 as well. We plan to look at this variation over the coming
15 year.
16 Another set of variation I wanted to show you as how
17 much variation there is by per benes. Here you can see this
18 is the percentile with the 10 percent, the least expensive
19 patients on the left-hand side, and the most expensive on
20 the right-hand side. The median was $466 and the average
21 was pulled to the right by the high-end spenders, users, on
22 the right-hand side, and the average is close to $900.

1 Spending on the most costly 10 percent of beneficiaries was
2 over $2,000.
3 I wanted to review with you some of the shortcomings of
4 the therapy caps that are scheduled to come back into play.
5 The large variation has considerable implications for what
6 the caps mean for individual beneficiaries. While imposing
7 the therapy caps is likely to control Medicare spending it
8 will do so indiscriminately. Specifically, the caps do not
9 vary by the care needs of beneficiaries. So as a result,
10 beneficiaries whose care needs exceed the limits will have
11 to pay for some of those services out-of-pocket or go
12 without them. Conversely, patients with low care needs will
13 not be affected by the caps, even though they may receive
14 services that are not medically necessary.
15 Another problem with the caps is they're not adjusted
16 for differences in payment rates across the country. What
17 that means is beneficiaries in low payment areas can receive
18 more services before they reach the limits than
19 beneficiaries who live in high payment areas. The caps
20 limit only the amount of spending but they don't address the
21 question of whether the services are medically necessary.
22 Finally, the caps do not tie payments to provider efficiency

1 or patient outcomes.

2 Given these problems, alternative policy designs might
3 do a better job of targeting spending and insuring that the
4 program gets value for its purchasing. Here I've outlined
5 four broad policy directions. These can be considered, and
6 they have very different abilities to control spending, to
7 encourage cost-effective practice, and to ensure beneficiary
8 access. Let me just walk through each of them very broadly.
9

10 The first set really looks at whether making different
11 therapy cap designs would improve the targeting of spending.
12 This would be a combined cap, three separate caps, you can
13 play with that in a number of different ways. These
14 alternative designs are likely to continue to disadvantage
15 beneficiaries with high care needs. And by themselves, the
16 limits are unlikely to insure that the services provided are
17 necessary or that they reflect best practice.

18 A second broad category of options would be to very
19 beneficiary copayments with the idea that some beneficiaries
20 might use fewer services if they had to pay more for them.
21 Examples here might include varying copayments by resource
22 use. Any such policy would need to include specific

1 provisions for low income beneficiaries so that their access
2 was not impaired.
3 Another broad category would be to compare practice
4 patterns, targeting the variation in service use. Comparing
5 practice patterns and developing best practice guidelines
6 would seek to narrow the variation that I've showed you a
7 little bit and start to begin to rationalize some of the
8 volume. Expanded medical review could target services that
9 don't meet coverage rules or that would appear to be
10 unnecessary.
11 Finally, the last broad category is to really think
12 about a different payment system that might begin to
13 encourage efficient service provision and move away from
14 fee-for-service medicine. Paying for broader bundles of
15 service, such as episode of care, on a prospective basis
16 would decrease the incentive to furnish unnecessary
17 services.
18 A completely different approach would be put the
19 management of therapy services out for competitive bid, so
20 on a per capita basis an entity would responsible for the
21 care or would contract it out.
22 Many of these possible strategies will need better data

1 about which patients receive therapy and what their outcomes
2 were. More accurate and complete diagnostic information is
3 needed to develop patient classification systems and to
4 adequately risk adjust payments. Without better clinical
5 information the payment system may disadvantage certain
6 beneficiaries and make it difficult to compare practice
7 patterns across patients and providers. More accurate
8 diagnosis information would also enhance the effectiveness
9 of medical reviews and help educate referring physicians and
10 therapists about typical and best practices.
11 Patient assessment information for therapy services is
12 also needed so that payments can be linked to performance.
13 Currently Medicare does not require providers to collect
14 patient assessment information. This makes it impossible to
15 assess the effectiveness of treatment or to evaluate if
16 higher spending is buying better patient outcomes. Value-
17 based purchasing strategies will allow on patient assessment
18 data to tie payments to performance.
19 Our future work, we plan to examine recent spending
20 increases to understand what services and settings and
21 beneficiaries account for the growth. We also plan to
22 convene an expert panel to discuss current practice

1 patterns, the feasibility of alternative policies, such as
2 practice guidelines or maybe episodes, and the data needs
3 that are required for improved payment policies. Staff will
4 explore alternatives to the therapy caps that might better
5 target therapy spending and our work will form the basis of
6 a chapter in June.

7 I'd like your guidance on what information and analysis
8 you will want to see as we explore the various policy
9 alternatives to the current therapy cap designs.

10 MR. HACKBARTH: In the grand scheme of things there's
11 not a huge amount of money here. On the other hand, this is
12 a recurrent issue that's been around for quite some time.
13 The existing policy of periodically reinstating these caps
14 is very hard to defend from any logical standpoint in terms
15 of getting patients what they need. So I think this is
16 something important to fix.

17 Just one quick question. What was the reason for
18 excluding hospital outpatient departments from the caps and
19 to what extent does that skew the delivery for people up
20 against the caps saying, I'm going to go to the hospital
21 outpatient department as a way to avoid it?

22 MS. CARTER: Hospitals were excluded originally to

1 ensure that there was a place for beneficiaries to seek care
2 if they were coming up against their limits. Therapy users
3 tend not to shift users, and that was true during the year
4 that the caps were in place. Over 90 percent of
5 beneficiaries receive their care from one provider. So it
6 didn't really acted as the safety valve that folks were
7 concerned about. That's my take on it.
8 MS. DePARLE: Although that was one of the arguments I
9 recall being made, at least by the nursing home industry
10 when the caps were put into place was that it was going to
11 mean that beneficiaries would be switched out to outpatient
12 departments, but it didn't actually happen.
13 I had one observation and then I guess the question.
14 Your comment, Glenn, reminded me of an interesting history
15 on this about where this came from. Mark will remember this
16 as will others here, Bill Scanlon and others. There were a
17 number of reports about increasing and unexplained use of
18 therapy, and no relationship between what was being used and
19 the results, that were out there. But where this really
20 came from was in the BBA final negotiations, when the CBO
21 scoring came back, they were trying to hit a budget number
22 and CBO said, you haven't hit that number and the poor staff

1 who were left trying to figure out what to do came up with
2 this as a way of -- it came up with the right number and it
3 put it in. I'm not saying there was no justification for
4 the policy. There were concerns about -- the same concerns
5 that Carol has talked about today were there. But that's
6 where the policy came from.
7 Jay was laughing when Carol went through the
8 disadvantages of it because it's hard to say what the
9 advantages are really. Other than that it's a great idea.
10 My question, this may fall into the category of further
11 work, but do we know the extent to which the growth is
12 occurring in physician offices versus in the other settings?
13 I guess some of the numbers and data that you showed us
14 reminded me of our discussion last year about imaging and
15 the Stark exception for the in-office ancillary services.
16 Does this full in that same category of things that
17 physicians can do and therefore is self-referral part of
18 what's going on here in growth?
19 MS. CARTER: Physicians are precluded from self-
20 referring to physical therapy facilities. We have not
21 looked at the spending growth to really know what the
22 spending increase is, particularly for the last year where

1 at least in CMS's letter to us in the spring about where the
2 physician fee schedule spending increases were coming from
3 and PT and OT were highlighted as an area of concern along
4 with other minor procedures.
5 MS. DePARLE: That made me wonder, so a doctor can't
6 refer that to his own office to be done? If I'm the
7 patient, Jay can't say, have it done in my office?
8 DR. STOWERS: To physical therapy? Yes, you can.
9 MS. CARTER: To his own office, sure. When you said
10 referral I thought you meant to a facility in which they had
11 ownership.
12 MS. DePARLE: I'm talking about in-office ancillary
13 exceptions to Stark. So do these services fall in that in-
14 office ancillary exemption?
15 MS. CARTER: Yes, and they would be incident to.
16 MS. DePARLE: So I guess my question is, is self-
17 referral part of the issue here?
18 DR. REISCHAUER: Have services provided in that setting
19 grown tremendously?
20 MS. CARTER: We don't know yet. I haven't looked at
21 the settings, but we will.
22 DR. SCANLON: Glenn, I agree with you that this is a

1 relatively small service, but it also exposes a potential
2 problem that's too often symptomatic of Medicare, which is
3 that we're paying for things that we don't even know exactly
4 what we're getting for it. This is maybe an extreme case.
5 Carol's review was excellent in terms of exposing the
6 absurdity of the situation in that we've got these claims,
7 we have a field called diagnosis and it's far from it in so
8 many cases.
9 How you move from this kind of a situation where you're
10 totally ignorant to something better is truly problematic.
11 I think you've got to think about this in terms of stages.
12 We're going to have to as a first stage potentially impose
13 some data requirements before we can actually think about
14 something that's more refined. But I do believe also that
15 when you are able to do the growth analysis over this two-
16 year period that may be very instructive about where some of
17 the problems may be, because you mention it's both numbers
18 of beneficiaries and numbers of services. The numbers of
19 services per beneficiary is way outweighing the numbers of
20 beneficiary increases.
21 So if this is like some of the other experiences we've
22 had with these smaller services where it's geographically

1 concentrated or provider-type concentrated, that may tell us
2 a lot about what we can do. But I do think in terms of the
3 policy options, when we get to that stage, that the one
4 that's germane today is probably going to be, get
5 information and then think about the options for the future,
6 because something radical here is potentially risky. We saw
7 in home health when we didn't understand the service and we
8 said, let's bundle things, let's create an episode, huge
9 changes that we still haven't fully appreciated. I think we
10 have to be careful here where we don't fully appreciate the
11 service. We don't fully have a good sense of the outcomes
12 that we're looking for.
13 DR. CROSSON: Accepting what Bill just said, when you
14 go through the policy options you describe you tend to
15 gravitate to some new payment system and bundling seems to
16 be the most attractive. So the question is, how feasible is
17 that? So I was starting to wonder, how many of the services
18 here can actually be tagged to a hospitalization or
19 something else that Medicare pays for so that you could
20 begin to track in some way what could be bundled? Is that
21 data that exists?
22 MS. CARTER: That would be one of the things we would

1 look at is to try to see how much of outpatient therapy is
2 related to post-acute, post-hospitalization, to start to
3 group things along those lines makes a lot of sense to me.
4 MR. DeBUSK: I just wanted to make a comment based upon
5 what Nancy said about in-office ancillary. There is a real
6 trend right now of physicians taking the physical therapy
7 back into their office and hiring the physical therapy
8 groups who run private practices in town because there's
9 been a major shift there.
10 When HealthSouth, they bought out all those physical --
11 I say all of them -- a lot of those physical therapies from
12 the doctors' offices across the country, there was a five-
13 year non-compete clause. That ran out, and with the changes
14 in the interpretation of the Stark law, the floodgates
15 opened. I'm not saying this a bad thing by any means, but
16 that's what's going on.
17 DR. KANE: As a former physical therapist I'd like to
18 at least defend the practices. They may be actually be
19 doing some good and we just don't know it yet. But I'm
20 hoping we can link it to the episode study, the study of
21 episodes of illness, and potentially see that it is in fact
22 often linked to some type of problem. Technology has

1 enabled us to do more and more orthopedic procedures on an
2 outpatient basis that often need physical therapy after.
3 I'm just trying to think of why volume would go up -- that
4 wouldn't just necessarily be something that we don't like.
5 But I think if in the course of doing the episode
6 grouping studies that are going on for the physician work
7 there can be some real effort to pull out the physical
8 therapy related claims and see how they relate to the type
9 of episode, I would think that would be more helpful than
10 trying to understand this in a vacuum of not knowing what
11 the patient was getting the treatment for or what else was
12 going on around the therapy. Like back pain you can get
13 physical therapy for to not need surgery. So I'm just
14 hoping you can somehow link all those claims up with what's
15 going on with the patient overall and put it in that
16 context. Then I strongly agree that we should be getting
17 better diagnostic information because speech therapists
18 don't do gait. That's bizarre.
19 DR. REISCHAUER: Carol, I thought this was very
20 interesting, but the most interesting number that I thought
21 you presented was the variation across states. The per-
22 beneficiary variation across states is five to one. I have

1 a hard time thinking of any other service category that per-
2 beneficiary would vary five to one across the states without
3 us seeing some -- you're going to come up with one.
4 DR. SCANLON: Pre-BBA, home health, Maryland to
5 Louisiana, five to one.
6 DR. REISCHAUER: But we were on a path -- different
7 states accelerated their egregious behavior with a different
8 rate but there were all going to end up at the same place.
9 DR. SCANLON: And when Carol is done with her growth
10 analysis we may same the same thing about this.
11 DR. REISCHAUER: That may be true, but we're asking
12 here, as was the case with home health, is this a needed
13 service? Are large portions of this of questionable value?
14 With Nebraska at a fifth of Texas you might be able to see
15 in Nebraska some outcome results from the denial or the non-
16 use of therapy. These are such stark and huge differences
17 that I think we should push that a little.
18 MS. CARTER: That's why I think the outcomes data is
19 really important. When you look at where CORFs are located,
20 they tend to be in high-cost therapies states. We may be
21 buying better services but we don't know that. They may be
22 treating more complicated cases.

1 DR. REISCHAUER: Where are the complicated cases in
2 Nebraska? Are they been unserved? That's the question.
3 Presumably the need is more or less the same across the
4 states; maybe vary 1.5 to one.
5 MS. CARTER: But we can't look at the outcomes across
6 these different providers at all.
7 DR. STOWERS: I'd just like to ask a question. There's
8 not a physician order required for physical therapy?
9 MS. CARTER: There is, yes.
10 DR. STOWERS: Because there's considerable variability
11 among the states in whether that's required or not under
12 licensure.
13 MS. CARTER: No, it's a Medicare requirement.
14 MR. HACKBARTH: We did a mandated report about a year
15 or so ago asking us to look at that particular question and
16 we said it's not sufficient in and of itself to assure
17 appropriate use, but we probably ought not eliminate the
18 physician referral requirement.
19 DR. KANE: The only other thing I was thinking of is,
20 in some of the places where physical therapy is delivered in
21 the SNF, some states may say that's where you get your
22 physical therapy and others may say you're going to get it

1 in a different site that you're picking up. Because you're
2 not picking up the claims that are done inpatient, right?
3 That are done by a person who sent post-acute to a SNF or a
4 rehab hospital. You're not picking up those claims. And in
5 other states they may be trying to get them in a CORF. Are
6 you picking them up? That's what I was trying to
7 understand.

8 MS. CARTER: We're not picking up the inpatient therapy
9 that would be associated with the Part A stay. But if
10 somebody was in a SNF because they didn't meet the skilled
11 service requirement or the prior hospitalization
12 requirement, they'd be inpatient in a SNF but they're not
13 being paid for by the inpatient benefit.

14 DR. KANE: But I'm just wondering if some of the
15 variability by state might be a reflection of the supply of
16 the different beds in the skilled nursing and the rehab
17 hospitals.

18 MS. CARTER: We should look at the supply of providers
19 across the states to see if that's an explanation.

20 MR. HACKBARTH: Anybody else?

21 DR. MILSTEIN: I think Nancy's suggestion would allow
22 us to re-examine this with a lot of more information. We

1 would, for example, know the probable diagnosis of every
2 patient who received physical therapy and also have an idea
3 based on the MEG analysis of their severity of illness.
4 Those are going to be huge explanatory variables in teasing
5 this apart. I think by the time we've adjusted for those,
6 with that better diagnostic information and severity of
7 illness variables, I'm going to expect that the variation
8 will decline.
9 MR. HACKBARTH: Thank you, Carol.
10 We're going to make a switch in the order of items on
11 the agenda and move right now to improving Medicare's
12 adjustments for geographic differences in underlying wage
13 levels. Then after that we will turn to the case study of
14 Maryland.
15 MR. GLASS: The basic idea in this is that if
16 underlying wages are higher in one area than another,
17 Medicare should pay more in the higher wage area because the
18 higher underlying wages are beyond any individual provider's
19 control. We're going to get into the guts of this but we
20 won't stay there for long. So we're looking at the Medicare
21 inpatient PPS -- that's the hospital inpatient, and that's
22 our example, because that system determines where a lot of

1 money goes in itself and it also serves as the basis for
2 geographic adjustments in all the facility-based PPS's such
3 as home health and SNF.
4 The way the formula works is the geographically
5 adjusted payment equals the base payment times the labor
6 share times the wage index. That's the part that's related
7 to labor. Then you add to that the base payment times one
8 minus the labor share and that's the part of payment that's
9 unrelated to labor costs. So wage index is underlying wage
10 level in a payment area relative to the national average,
11 and labor share is the proportion of the base payment that's
12 adjusted by the wage index, and that should be the
13 proportion of costs that are labor related. So labor
14 related are things like wages and benefits, and not labor
15 related would be things like supplies bought on a national
16 market like an MRI machine.
17 So to look at a simple example of this, in an expensive
18 MSA the base payment is going to be the same everywhere, and
19 you're multiplying it times the labor share, which is 0.7 in
20 this example, and times 1.5. That means that the underlying
21 wages here are 1.5 times the national average. If you do
22 the little calculation you end up with $6,345 in the

1 expensive MSA is your payment, and in the inexpensive MSA
2 where costs are 0.8 of the national average you end up with
3 $4,117. You may note that labor share here is slightly
4 different and Jeff's going to explain why that is. If the
5 labor share was 0.7 in the latter example the number would
6 be even smaller, about $4,000.
7 So that's the way the system works. It looks simple
8 enough but there are some perennial wage index issues. What
9 should the labor market area be is first one. Currently,
10 it's the metropolitan statistical areas, each of those has
11 its own wage index, and the statewide rural area which are
12 all the counties that aren't in an MSA in the state, they
13 have one wage index for that group of counties.
14 So the problem here is that both of these can be large
15 areas. When you have large areas you could have multiple
16 labor markets inside of those areas. So that could be a
17 problem. And you have boundary problems. For instance, the
18 Washington MSA has a wage index of about 1.09, and Jefferson
19 County, West Virginia is in that MSA. It sits next to rural
20 counties in West Virginia which have a wage index of 0.77.
21 So you can have fairly large changes at the boundaries. So
22 that's always a problem.

1 Partly in response to that you have the question of
2 reclassification. Reclassification is where you can get the
3 wage index of someplace else that you're not. That has
4 become a large number of hospitals, like a third of them.
5 So that's kind of a problem too. That's a perennial issue
6 of how should you do the reclassification.
7 MR. DeBUSK: A political football.
8 MR. GLASS: So then the other basic problem is what
9 data should be used to reflect underlying wages, and
10 currently we're using hospital reported wages. They
11 calculate an average wage for the hospital and that's what
12 the wage index gets based on. The problem with that is the
13 occupational mix problem, which I'm going to talk to on the
14 next slide. You can have differences among hospitals in
15 just how they do business; if they contract out all the low-
16 wage employees their average wage is going to look high in
17 relation to some hospital that doesn't do that.
18 The occupational mix thing, here's a little simplified
19 example. In MSA one we're going to have three occupations,
20 RNs, LPNs and everyone else. They have 10,000 hours for
21 RNs, 5,000 for LPNs, 5,000 for everyone else. And RNs get
22 paid $20 an hour, LPNs $10, others $15. Now in MSA two it

1 turns out the wages are the same, 20, 10 and 15 but we've
2 switched the hours so LPNs are now performing 10,000 hours
3 in MSA two and RNs only 5,000 hours in MSA two versus vice
4 versa in MSA one.
5 If you do the calculations you get average wages of
6 $16.25 in MSA one and $13.75 in MSA two. If you did a wage
7 index from that the wage index MSA one would be 1.08 and
8 0.92 in the other one. So there would be a big difference
9 in the wage index between these two. But the underlying
10 wages in these two MSAs are identical. They're $20 for RNs,
11 $10 for LPNs and $15 for everyone else. So in fact the wage
12 index should be identical and not differing as much as it
13 does here. That's the occupational mix problem. You'd like
14 the wage index to be identical in these two cases.
15 Someone could say, wait a minute, the hospitals' costs
16 are going to differ. In MSA one they're going to spend a
17 lot more on labor and therefore the labor mix should be
18 higher. But in fact if they're doing that because they're
19 doing more complex cases in MSA one versus MSA two, the wage
20 index isn't meant to take care of that problem. That should
21 be reflected in the case-mix index. And if they're doing it
22 just because they like the RNs, the management just decides

1 they like to use more RNs, we don't want to pay for that
2 either in Medicare. So neither of those should be reflected
3 in the wage index which in this example, as I said, should
4 be the same for both. So that's the occupational mix
5 problem.
6 DR. REISCHAUER: The occupational mix is calculated on
7 an MSA basis or hospital by hospital?
8 MR. GLASS: The basic system wouldn't have occupational
9 mix in it at all but they've now started to look at it on a
10 hospital by hospital basis.
11 DR. REISCHAUER: But if it's a hospital by hospital
12 basis then as you change your mix, your wage index changes.
13 MR. GLASS: Let me get to that right here on this
14 next slide because in fact CMS has started to do some
15 adjustments for occupational mix. In fact that's one of the
16 current wage index issues, one of the reasons why we think
17 it's time to look at this again. What's going on is that a
18 hospital sued and said, the law says you're supposed to
19 adjust for occupational mix and you're not. You're only
20 adjusting at the moment 10 percent for occupational mix and
21 90 percent is not adjusted. Part of the reason -- CMS's
22 position was they did a survey to try to get to the

1 occupational mix problem where they looked at each
2 hospitals's occupational mix but they found that some of the
3 results were not what they expected and they didn't want to
4 credit the results too much, partly because they surveyed
5 hours only. They didn't survey hours and wages so they
6 couldn't really do the occupational mix adjustment you might
7 want to do. So this is a live issue at the moment.
8 Now your question was what exactly, because I'm not
9 sure if this answered it?
10 DR. REISCHAUER: You've answered it.
11 MR. GLASS: As we talk through this, one of the ways we
12 think you might want to calculate the wage index will kind
13 of automatically take care of the occupational mix issue, so
14 that would probably be an easier solution than this.
15 One of the other issues is the one and two hospital
16 MSAs. There are MSAs that only have one hospital in there.
17 There are MSAs the only have two hospitals in them. The
18 wage index is calculated on an MSA level, so if you only
19 have one hospital, the hospital is essentially dictating its
20 own wage index, and if it does something like changes how it
21 contracts out it can bump its wage index up or down and that
22 volatility is probably not a good thing.

1 There's also an increase in the number of critical
2 access hospitals. I think there was 1,100 of them at the
3 beginning of the summer and the number was still growing.
4 The problem with that is they don't count in the wage index
5 calculation so you can end up with areas with very few IPPS
6 hospitals to calculate your wage index from, and if you have
7 a large statewide rural area it could be that those
8 hospitals might be over in one corner and yet you have SNFs
9 and home health agencies in another corner and the wage may
10 not be particularly representative for them. So we think
11 that's another current wage index problem.
12 Then you have what I call the tail wagging the dog
13 problem where you have so many exemptions now you can get
14 some odd things cranking up. In one state, for example,
15 there are two rural hospitals that determine the statewide
16 rural wage index. But the value that results from that is
17 higher than many of the urban hospitals get if they
18 calculate their wage index. And there's a rule that if an
19 urban hospital has a wage index lower than the statewide
20 rural, it gets the statewide rural. It's called the rural
21 floor. So in this state almost half the hospitals are now
22 getting this statewide rural floor that's constructed from

1 two rural hospitals. So you get the tail wagging the dog.
2 It's a symptom of a systemic problem with the whole system
3 and the reclassification.
4 Jeff is now going to talk about the labor share issue,
5 which you can see is closely related.
6 DR. STENSLAND: As part of our report on the rural
7 provisions of the MMA we are required to analyze the
8 mandated changes to the hospital's inpatient labor share.
9 Under the MMA, hospitals in areas with below-average wage
10 rates use a labor share of 62 percent, while hospitals in
11 higher-wage areas continue to use the standard labor share
12 which is 70 percent. The effect of this provision is to
13 increase payments to hospitals in low-wage areas. It is not
14 budget neutral and we are required to analyze the effect of
15 this provision on Medicare payments.
16 In addition to computing the change in payments, we
17 plan to analyze the pros and cons of having two labor shares
18 rather than one uniform labor share. We've also discussed
19 methods for calculating the labor share. CMS uses an
20 accounting approach. They sum hospitals' labor related
21 costs, such as wages, benefits, and labor-intensive services
22 and divide by total costs. There is some imprecision in

1 determining what services are labor-intensive.

2 An alternative is to use a regression approach to
3 evaluate how hospital costs per discharge differ as the wage
4 index differs, controlling for other confounding factors.
5 This regression approach allows for the fact that hospitals
6 may choose to use more labor when it's less expensive and
7 use less labor when it's more expensive. CMS has attempted
8 this regression approach but to date has been unsatisfied
9 with the stability of the regression results and has chosen
10 not to use them.

11 We propose to examine the wage index and then examine
12 the labor share issue. Our contractor will compare the
13 theoretical arguments supporting the current system to the
14 theoretical arguments supporting a fixed weight system.
15 Then our contractor will create a fixed weight index. The
16 index will be created by first collecting data from the BLS
17 or census on the average wages paid to people in different
18 occupations, for example, nurses and pharmacists. Second,
19 the contractor will construct a fixed weight index for
20 hospitals by taking a weighted average of those wages in
21 different labor market areas.

22 To test whether this alternative system performs better

1 than the current system we will use several evaluation
2 criteria. The contractor will develop a cost function to
3 compare how well payments match costs under the current
4 system and the alternative system. In addition, we will
5 examine the stability of wage indexes over time in the two
6 systems, the administrative burden of the systems, and
7 examine the boundary discussions that David discussed. We
8 want to avoid having hospitals that are 10 or 20 miles apart
9 having significantly different wage indexes and hence
10 significantly different payments.
11 This study of hospital wage index can be seen as a test
12 case. It may be possible to create a common set of regional
13 wages to compute wage indexes for all sectors. The wage
14 indexes could be tailored to fit each sector by using
15 different occupational weights for each sector. For
16 example, the hospital wage index may place a higher weight
17 on pharmacists than the SNF wage index. The home health
18 agency index may place a higher weight on nursing aides.
19 The goal was to have a single framework computing wage
20 indexes that can be adjusted to fit each sector better than
21 the current wage index system.
22 In addition to a quantitative comparison of alternative

1 approaches we also tried to bring you a framework for
2 thinking about what the underlying goals of the wage index
3 should be. We now look forward to hearing your comments on
4 our workplan.
5 MR. HACKBARTH: I'd hazard a guess that there probably
6 aren't many more issues that have consumed more analytic,
7 administrative and political resources than this one. This
8 has been a struggle for 25 years.
9 MR. MULLER: In addition to the rural there's a few
10 other -- can you remind us of some of the other ones?
11 MR. GLASS: Do you mean other reclassification?
12 MR. MULLER: Yes.
13 MR. GLASS: There's the basic reclassification thing
14 where if your hospital exceeds its area wage index by a
15 certain amount and it's close enough to some other
16 neighboring one by a certain amount then you can get their
17 wage index. They also had something called Section 508 --
18 one-time reclass thing that was not budget neutral that I
19 think sent $900 million over three years to certain
20 hospitals that got to reclassify to higher wage index.
21 MR. MULLER: What proportion of either the hospitals or
22 the payment issues are around those special classifications,

1 do you have a sense? It strikes me it's a big set.
2 MR. GLASS: It's like a third of hospitals are
3 reclassified one way or another.
4 DR. REISCHAUER: What fraction of beds or costs is the
5 real thing you want to ask.
6 MR. GLASS: That I don't know. We could find that out.
7 DR. STENSLAND: But we suspect that would be smaller.
8 DR. REISCHAUER: Yes, considerably.
9 DR. STOWERS: Something we experienced out in the rural
10 area where we practice is that sometimes the nurses, which
11 was the biggest cost, were driving great distances to work
12 in the urban setting because the wages were a lot higher.
13 So they paid less -- because the rural hospital paid less
14 because their wage index was less. So it's kind of like
15 chasing your tail when you're in those settings because --
16 so the decision comes at the hospital but they're at the
17 rural wage index so they start having to compete with the
18 urban or the metropolitan rate in order to try -- but it
19 doesn't change the state index.
20 It really adds to the problem of getting physical
21 therapists and nurses and that kind of thing into these
22 areas. So I think this boundary thing is tremendously

1 important and I just somehow think we really totally got to
2 reevaluate this metropolitan, non-metropolitan part because
3 it's not uncommon for nurses, because of the wage
4 difference, to drive 60 or 70 miles one way a day in order
5 to jump into another a set of wages and levels. I may be
6 misperceiving that but it seemed to be the situation that we
7 were living in there.
8 DR. REISCHAUER: I think we've adopted policies
9 recently to take care of that called higher gasoline prices.
10 DR. STOWERS: Which is going to aggravate the situation
11 even more.
12 MR. GLASS: There's also an out-commuting provision
13 they've put in where if your county has enough people that
14 are computing out of the county to higher a wage county your
15 wage indexes is essentially blended. We will probably look
16 at some blending approaches.
17 DR. STOWERS: I think we need to.
18 MR. HACKBARTH: The exceptions of various types have
19 pretty well eaten the basic rule here and digested it.
20 DR. WOLTER: It would be interesting if you could pull
21 it together for us to actually look at a bell curve in terms
22 of annually what percentage of hospitals get marketbasket or

1 above marketbasket and what percentage end up getting less
2 than marketbasket, because I think that the variation there
3 would be quite interesting. I understand there are some
4 institutions that might actually get a negative, a very
5 small number, and then others are probably getting five or
6 six or 7 percent increases.
7 MR. GLASS: I don't quite understand.
8 DR. MILLER: I think what he's referring to is --
9 DR. WOLTER: Once the city inpatient update is done
10 what percentage of institutions are over a range, at
11 marketbasket, above it or less than it.
12 MR. GLASS: You mean because of changes in their wage
13 index?
14 DR. WOLTER: Current wage index. I know in my own
15 institution's case we haven't had a marketbasket update for
16 many years, even though we've seen marketbasket in law the
17 last couple of years, and that's because of wage index
18 issues. I think the system now because of all of this
19 reclassification, because of issues like outsourcing and all
20 those kinds of things, when you're seeing 5 percent and 6
21 percent annual wage increases, anybody that would be less
22 than that is going to end up having their wage index go down

1 even though they may be under wage pressures that are above
2 marketbasket.
3 So it may well be that we have some good institutions
4 facing chronic less than marketbasket updates because of a
5 payment system now around which so many exceptions have been
6 created, create some anomalies. So I think this is really
7 important work. It's going to be difficult and I think the
8 policy changes will be difficult, but I think there are some
9 problems here that really need attention.
10 MR. HACKBARTH: I think there are real compelling
11 reasons to conclude that the system doesn't work. Of
12 course, one of the most basic problems is you come up with a
13 new system it's going to entail some redistribution. People
14 have worked long and hard to get their reclassification or
15 special status are then going to potentially lose it and
16 those are hard politics for sure.
17 Other questions, comments?
18 Okay. So, Craig, you're going to lead the way on -- or
19 Jack is?
20 MR. ASHBY: This session is going to be about the
21 Maryland rate setting system. Before I begin, for just a
22 moment, we were to have the executive director of the

1 Maryland rate setting commission, Bob Murray, with us today.
2 He is, unfortunately, not here yet but I nonetheless wanted
3 to, for the sake of the record just thank the Maryland staff
4 and consultants. They've been very generous with their time
5 and expertise on this and other projects and we certainly
6 appreciate their help.
7 Maryland is one of several states that implemented all-
8 payer rate setting systems during the 1970s. But for more
9 than a decade now they are the only ones still operating.
10 The system addresses all of the key features of Medicare's
11 several inpatient and outpatient PPS's. So in this project
12 our goal was to find out what we can learn from their
13 experience that may help us in assessing the adequacy of
14 payments and other aspects of Medicare payment policy.
15 We wanted to stress though that we are not endorsing
16 the concept of rate setting. The Maryland system is quite
17 complex, as we'll learn in just a moment, and state
18 regulation involves mechanisms that some might find
19 intrusive. But we still think that there are some aspects
20 of the system that we might learn from, and in some cases we
21 might benefit from using their data.
22 Our presentation will focus primarily on six specific

1 features of the Maryland system that have particular policy
2 interests. These are the pattern of cost growth. That
3 relates to our March report work about the effects of
4 pressure from private payers on cost growth. Payment based
5 on resource use, as the Commission discussed at our April
6 meeting and for physicians a moment ago. The markup of
7 charges over costs, which relates to how accurate our
8 estimates of Medicare inpatient and outpatient costs are in
9 the Medicare cost report which Nick and others have been
10 interested in. And also the very current issue of the
11 prices that the uninsured are expected to pay.
12 Then there's payment for uncompensated care, also use
13 of financial indicators. You'll remember that the Congress
14 asked us to report on that issue last year. And a unique
15 borderless wage index system that operates in Maryland,
16 hearkening back to our discussion just a moment ago about
17 the border issue. But to understand these issues we need to
18 provide some background information on the Maryland system.
19 Rate setting began in Maryland in 1974. It covers both
20 inpatient and outpatient services. The consensus needed to
21 get the system enacted in the first place was built around,
22 first, hospitals' interest in covering their unusually high

1 uncompensated care costs and the state's and leading payers'
2 interest in reducing hospitals' high costs. It appears that
3 both groups have achieved their goals as the costs of
4 uncompensated care are included in the rates that all payers
5 pay. And because cost per adjusted admission -- that's an
6 all-payer, all-service measure -- have gone from 25 percent
7 above the national average in 1976 to about 4 percent below
8 the national average today.

9 Maryland's waiver, by the way, from Medicare payment
10 requires that its cumulative growth in Medicare inpatient
11 payments per discharge not exceed that of the Medicare
12 program nationally.

13 Just a moment on the hospitals in Maryland. The rate
14 setting experience may have been aided by the relatively
15 small size of the state, 47 hospitals, and by the
16 homogeneity of its hospitals. There are no public hospitals
17 and only one for-profit.

18 The unit of payment in Maryland is charges for specific
19 services. Of course there are thousands of these services.
20 There is a urinalysis, an MRI, a minute of OR time and so
21 forth. These rates do apply to all payers, although anyone
22 can get a 2 percent discount for prompt payment and Medicare

1 and Medicaid get a 6 percent discount. But very
2 importantly, private payers cannot negotiate discounts with
3 hospitals. So with the exceptions of these limited
4 discounts charges and payments in Maryland are virtually one
5 and the same.
6 Since the 1970s when they did individualized rate
7 reviews to set base rates the system has followed a
8 formulaic process. The three red boxes that you see here
9 mirror the basic process of Medicare, inflating a base rate
10 by an update factor to arrive at the rate for the coming
11 year. But in Maryland rather than a single base rate as we
12 have in Medicare, each department, each inpatient,
13 outpatient and ancillary department has its own base rate.
14 It's in the form of an average charge per unit of output.
15 That would be like average outpatient charge per visit,
16 average operating room charge per minute or whatever. Then
17 there's the extra step of the hospitals' converting these
18 departmental averages into a chargemaster that covers the
19 array of services in that department.
20 In Medicare, the same update applies to all hospitals.
21 And in Maryland, they too have a general update factor that
22 applies to all hospitals based on the same marketbasket that

1 we use. But then the update is customized for it each and
2 every hospital. It's done in three different ways, which
3 I'll take a look at on the next slide. But first, just a
4 brief reference to the last component of the system, they
5 can still request a full rate review if they would like.
6 They can get consideration of special factors and
7 circumstances.
8 The chart here shows that to get a full update a
9 hospital basically has to meet these three tests. First,
10 did the department's chargemaster over the last year bring
11 in aggregate payments that are consistent with the group
12 rate? If the payments coming in were too high they have to
13 rebate that amount and there may be a penalty, depending on
14 how much over they are.
15 Secondly, did the hospitals' inpatient charge per
16 discharge increase more than the general update? If yes,
17 they're penalized. If no, they are rewarded. This test
18 guards against hospitals increasing length of stay or using
19 more ancillary services in the course of a stay, which is a
20 natural incentive of using charges as the unit of payment.
21 Then finally, was the hospital's inpatient charge per
22 discharge, in the absolute, higher than its peers? This is

1 basically payment for resource use. Again, if the answer to
2 the question is yes, they are penalized. If no, they are
3 rewarded. I'll have a little bit more on this very unique
4 feature of the system in a moment.
5 Now we're going to go through briefly the six key
6 features of the system that we listed at the beginning,
7 beginning with cost containment longitudinally. As all
8 PPS's do, the Maryland system attempts to control cost
9 growth over time. We don't have time to review all of the
10 mechanisms that they use to do that -- there's more in your
11 briefing books -- but what I did want to highlight was their
12 pattern of cost growth. You will recall in the March report
13 we showed that the rate of growth in Medicare cost per
14 discharge, as you see here, has fallen into three distinct
15 periods. In short, back in the late '80s there was very
16 high cost growth when private payers exerted very little
17 pressure; low cost growth in the '90s when health plans were
18 providing a lot of pressure; and then higher cost growth
19 again since 1999, after the pressure has again subsided.
20 In Maryland though we have a natural experiment here.
21 They did not have changes in pressure from private payers
22 because private payers are not allowed to negotiate with

1 hospitals. Without that influence Maryland hospitals
2 haven't experienced nearly as large a swing in rate of cost
3 growth as you see in the chart here. In the first period
4 their cost growth was a couple of percentage points lower
5 every year, in the middle period, a couple of percentage
6 points higher, and since '99 again it's once again lower.
7 In fact in the last two years it once again is a full two
8 percentage points per year lower than what has been
9 happening in the rest of the country.
10 The next issue is looking at cost containment cross-
11 sectionally, the payment on resource use. This system
12 begins with a measure for comparison, a standardized
13 inpatient charges per case. It controls for six different
14 variables that are thought to be exogenous to the hospital.
15 And then on this measure hospitals are compared to their
16 peers using five groupings defined on teaching status and
17 urban/suburban/rural location. Any hospital whose
18 standardized inpatient charge per case is 3 percent above
19 the mean for its peer group has to negotiate what they have
20 called a spend-down plan. That generally means they're
21 going to have one point to 1.5 points shaved off of their
22 update for as many years as it takes to get their costs down

1 to group mean.

2 That deals with the high side. But on the low side
3 hospitals can generally get their charges increased to a
4 level that would bring them up to 2 percent below mean
5 through a full rate review. When we remember that this
6 resource use payment extends to all payers it obviously is
7 going to have a powerful effect.

8 Looking to the future on this one, the rate setting
9 agency plans to extend this resource use measure to
10 outpatient care soon. They will be basing the comparison
11 there on charge per APG. That we believe is breaking new
12 ground. We have seen resource use payments in the private
13 sector. To our knowledge they have not been extended to the
14 outpatient sector.

15 Secondly, they have developed a proposal for combining
16 quality and resource use measures into a single payment
17 adjustment for efficiency. As many of you know, Maryland
18 hospitals have been reporting a uniform set of quality
19 measures for a number of years that they can access for this
20 system.

21 The next issue is mark-ups, the mark-ups of charges
22 over costs. Because charges are regulated in Maryland as we

1 described, the average markup of charges over costs has
2 hardly changed at all over the last 20 years as you see on
3 the bottom line of this graph. But in the rest of the
4 country we've seen a steady increase in the mark-up as
5 hospitals try to leverage additional payment from insurers
6 that are paying on discounted charges. In other parts of
7 the country we have reached the point where the average
8 mark-up is 150 percent, certainly a healthy mark-up. Those
9 charges are what the uninsured are asked to pay, at least
10 initially. In Maryland, on the other hand, the insured and
11 the uninsured patients pay exactly the same rates.
12 On the next slide we look at a different aspect of the
13 mark-up issue. Maryland also requires that the mark-up be
14 equal for every type of service, every department,
15 inpatient, ancillary and outpatient, across the hospital.
16 They are not necessarily required to have an equal mark-up
17 on each individual service, urinalysis versus a CBC, but the
18 rate setting staff believe that many hospitals do so
19 voluntarily because it's an efficient way to ensure that the
20 amount they collect is consistent with their improved rates.
21 Now we've talked numerous times in the past about how
22 charges are used to allocate cost between inpatient and

1 outpatient in the cost report and we've had concerns about
2 the accuracy of these allocations given hospitals' widely
3 varying mark-ups. With Maryland hospitals' consistent mark-
4 ups we may be able to use Maryland data to shed light on
5 this question that's been a very elusive one for us. And it
6 is an important question because it determines the relative
7 adequacy of Medicare's inpatient and outpatient payments.
8 I have to caution that it's hard to know whether the
9 Maryland hospitals submit data that is really comparable to
10 what is submitted by other hospitals since those data are
11 not used in payment as they are in other areas, but at any
12 rate, the rate setting staff has expressed their willingness
13 to work with us on this project and we'll just have to find
14 out whether it proves feasible and enlightens the issue.
15 With that I turn it over to Craig for the last couple
16 of issues.
17 MR. LISK: First I'm going to cover uncompensated care.
18 One of the unique features of Maryland's payment system is
19 the cost of uncompensated care are recognized in its payment
20 rates as they are incorporated into the approved charges
21 that they have in their chargemasters. Because all public
22 and commercial payers pay a given hospital using the same

1 charges, all payers contribute to covering these expenses.
2 The adjustment is prospective, thus actual
3 uncompensated care costs in any given year are not directly
4 reimbursed. But hospitals with historically a higher
5 uncompensated care patient loads will generally be provided
6 with higher charge mark-ups to help cover the costs of
7 uncompensated care. Maryland's goal was to cover the full
8 reasonable amount of uncompensated care including bad debt
9 and charity care. They recognized, however, that full
10 coverage could weaken hospitals' incentives to collect on
11 patients' accounts. They therefore developed a prospective
12 system which uses an algorithm that considers both their
13 actual uncompensated care experience and a predicted value
14 from a regression model to determine the charge mark-up for
15 uncompensated care. The regression estimate serves as a
16 test of reasonableness.
17 Moving on to the issue of the financial indicators.
18 The Maryland system uses a set of indicators and targets to
19 gauge the financial condition of its state's hospital
20 industry and to determine if adjustments might be needed to
21 the payment rates. The current set of indicators and their
22 respective targets are pictured in the overhead. The

1 financial indicators and targets were developed in
2 consultation with the hospital industry, payers, bond rating
3 agencies and other financial experts. The indicators were
4 kept to a small set of easily interpretable measures out of
5 concern that a larger set would lead to disagreements over
6 what measures were most important and to inconsistent
7 results among measures.
8 The targets were set to ensure that the rates provided
9 to hospitals are reasonable, so that if a hospital operated
10 efficiently and effectively it will remain solvent and will
11 receive a fair return on its assets. No one target,
12 financial or operating, was intended to be viewed as
13 dominant. They were all evaluated together before
14 conclusions are drawn to the financial condition of the
15 industry. The targets are not used to judge the performance
16 of individual hospitals.
17 The targets are periodically reevaluated to account for
18 changing industry circumstances. The current set of targets
19 you see in the overhead were developed in 2001 and were
20 designed to facilitate a gradual improvement in the
21 financial condition of Maryland's hospitals who were
22 becoming undercapitalized.

1 Moving on to the last topic, the wage index.
2 Medicare's wage index system establishes wage index values
3 for MSAs and statewide rural areas, as David and Jeff have
4 just discussed. The approach results in borders between
5 areas with wage index values that can differ substantially
6 between neighboring areas. On this overhead here you can
7 see the Medicare wage index values for Maryland hospitals.
8 On the left are the rural hospitals, in the middle is the
9 Baltimore MSA and on the right is the Washington, D.C. MSA.
10 As you can see there are significant differences between
11 these three wage index areas and no variation of the index
12 in between and within areas.
13 Maryland has designed and implemented an alternative
14 approach to adjusting for differences in prevailing wage
15 rates which differs from Medicare's. The Maryland system
16 defines a hospital's market based on the zip codes from
17 which it draws its own employees, such that it does not
18 involve borders. It also fully adjust for occupational mix.
19 The net result is the Maryland system smooths the
20 progression of wage index values, shown as the red diamonds
21 on the overhead, within and across areas. In addition, wage
22 index values under Maryland systems are much tighter with a

1 spread of 10 percentage points compared to 19 percentage
2 points under Medicare. Some of this narrowing may be from
3 controlling for occupational mix which allows the index to
4 reflect only differences in wage levels rather than
5 differences in the mix of employees.
6 So now let me walk you briefly through what happens
7 with the Maryland wage index in the different markets.
8 Let's first look at the far left which is the rural
9 hospitals. The lowest values are for hospitals that are the
10 furthest from the urban areas, and they move up to the next
11 group for sets of hospitals that are a little bit closer to
12 the urban MSAs.
13 If we next move to look at the D.C. metro area, the
14 lowest values are for hospitals in the outer fringes of the
15 D.C. metro area that are in Maryland and it moves up as you
16 get to the suburbs that are closer into D.C.
17 So in essence it appears as though the wage index
18 values in the Maryland system reflect some of the cost of
19 living differences within the state of Maryland and provide
20 a smoother progression of wage index values between areas.
21 To run this system, Maryland annually collects from all
22 hospitals for a set two-week period each employees zip code

1 of residence, their job category, hours paid, and total
2 wages paid, a substantial amount of data. Hospitals were a
3 partner in developing this new system and they have been
4 willing and able to provide these data to the rate setting
5 commission to administer it.
6 So as David and Jeff discussed, the Maryland system may
7 have some attributes that we may want to consider in
8 developing some of the reforms we are considering for the
9 wage index
10 Finally, in review, you might want like to discuss
11 further some of the issues that have potential applicability
12 to Medicare. This includes the cost control measures that
13 are part of the Maryland system, particularly the reward and
14 penalty for resource use. Another is the potential
15 applicability of the financial measures and targets used to
16 judge the health of Maryland's hospital industry. A third
17 issue is the approach Maryland took to creating borderless
18 wage index values.
19 We will now be happy to answer any questions that you
20 may have and look forward to your discussion.
21 MR. HACKBARTH: Can I ask a question about the wage
22 index? I'm not sure I understand how the Maryland system

1 works yet. In Medicare, the original guiding principle at
2 least was that we wanted to create an index as an element of
3 prospectivity and reward institutions that managed their
4 wage costs, among other things, and kept their costs low.
5 So we didn't want individual hospitals to control the amount
6 they got paid for wages. We didn't want to just cost
7 reimburse whatever their wage level was.
8 Maryland, the way I'm understanding it is that each
9 hospital has its own unique wage adjustment based on where
10 it draws its people from?
11 MR. ASHBY: Right, but the thing to remember is that
12 the hospitals' wage index value is not based on the wages
13 that it pays its employees, so it's not self-directed any
14 more than the Medicare payment system is.
15 What it does is that for each employee, it goes to the
16 zip code that that employee lives in and takes the average
17 wage of all hospital workers that live in that zip code who
18 might work for 10 different hospitals around the area. So
19 all it's doing is adjusting these averages down to the zip
20 code level rather than creating averages for this very broad
21 area of an MSA.
22 MR. LISK: But for an isolated hospital you very well

1 could have the average of their wages being influenced in
2 terms of what they're paying.
3 MR. HACKBARTH: The extent to which it works depends in
4 part of the nature of the geography and the commuting
5 patterns.
6 MR. LISK: Correct.
7 MR. ASHBY: But when you think of a fairly outlining
8 hospital, in the Medicare system it could very well have an
9 MSA of its own, so it is literally 100 percent self-driven
10 and that's a bad outcome. In this system it's less likely
11 to be 100 percent self-driven no matter where they are. But
12 it becomes gradually more self-driven as you get out to
13 sparsely populated areas.
14 DR. REISCHAUER: But why would you want the wage of
15 hospital-based workers from that zip code, as opposed to
16 nurses living in that zip code? I mean it's a strange way
17 of doing things if what you're interested in is the supply
18 of labor qualified to fill a job and physically capable of
19 working in a location where the hospital is.
20 MR. LISK: They're essentially looking at where the
21 hospital draws its labor from. Then they're looking at for
22 a specific occupation like nurses, they're calculating the

1 average wage for nurses in that zip code for all hospitals.
2 It is for hospital workers though. It's limited because of
3 how they're collecting the data in that way. So there's
4 other alternatives for how you collect the data.
5 MR. ASHBY: That creates a bit of a trade-off between
6 what David was talking about, census data, for example, do
7 have the distinct advantage of being all settings so they we
8 have better applicability across settings and they better
9 represent the market. This, alternatively, is limited to
10 hospital workers but has the advantage of being able to
11 fine-tune the labor market areas better because you know
12 where the employees originate.
13 DR. MILLER: For the Commission, the way I would
14 suggest you think about it is if this concept were
15 considered for Medicare it would be the notion of trying to
16 build wage indexed based on where people come from and
17 probably using something more generalized like census data
18 rather than going to zip codes for individual workers and
19 trying to build at that level, which would be pretty
20 daunting for the entire country. As a concept, if you want
21 to play with it, that's more --
22 MR. ASHBY: Exactly, that would be a move in that

1 direction.

2 MR. HACKBARTH: Other questions and comments?

3 MR. MULLER: On page 15, the operating indicators are
4 pretty consistent with Moody's and S&P level, and some of
5 them even so on average. I take it they're performing at a
6 pretty good level looking at these indicators.

7 MR. LISK: The targets were designed -- actually
8 Maryland found themselves to be undercapitalized, so they
9 designed their targets to increase their levels. So they
10 were designed so that they'd increase their operating margin
11 some and their total margins. They had an average age of
12 plant that was like 9.3 years which they were concerned
13 about so they wanted that to go down. So some of this was
14 to bring up the numbers, possibly an increase in debt to
15 capitalization thought from what they had, but also increase
16 cash on hand to increase their financial circumstances. So
17 that was part of the goal is as they were looking at --

18 MR. HACKBARTH: Are you implying that the actuals do
19 approach the targets pretty well?

20 MR. LISK: The actuals that were in place when they put
21 these targets in, the operating margin, total margins were
22 lower than these numbers. So they were having a three-year

1 number to get to this period at the end of 2005.

2 MR. HACKBARTH: At the end of the period they're

3 getting there?

4 MR. LISK: Right.

5 DR. KANE: The other thing about the financial measures

6 that Maryland does that I think you have to think about if

7 you're going to start looking at financial indicators and

8 using them as targets is what do you do if a hospital

9 doesn't come close to that? What Maryland does is consider

10 whether it should close and does a little bit of planning

11 about whether access would be compromised. If they think

12 it's fine to close the hospital they take the steps to close

13 the hospital. One of the things about taking responsibility

14 for financial performance is also saying, if you're not

15 cutting it, we're going to take action.

16 MS. DePARLE: So have they?

17 DR. KANE: I think five hospitals have gone --

18 MR. ASHBY: Right, but let's just parse two different

19 issues here. What they don't really do is apply these

20 standards to individual hospitals. They're very explicit in

21 not doing that. They're not really saying that it's

22 necessary for every hospital to be at these levels. It's

1 intended to judge the industry.

2 DR. MILLER: But just to pick up on her point though

3 for just a second, there is something that goes on when they

4 think a hospital needs to be dealt with. Isn't there some

5 adjustment for hospitals around it that take its business?

6 MR. ASHBY: Right. Let me explain that because it is

7 an interesting feature. If the hospital is in financial

8 trouble the agency will be given the job of assessing

9 whether access would be compromised if the hospital closed

10 and whether the aggregate cost of the system would be

11 reduced by its closing. If the answer is no anticipated

12 access problems and that there would be savings from the

13 hospital closing, then yes, they do move in that direction

14 and they have the capability of using state monies to pay

15 off any debts that they have and cover their closing costs.

16 Then the cost of that closing is tacked onto the rates for

17 the other hospitals to reach equalization.

18 It's an interesting approach and they have had five

19 closures that have been endorsed and accomplished with that

20 mechanism over the last decade.

21 DR. KANE: I think it's important to note that when you

22 start to worry the financial performance it can go both

1 ways. You can say, let's improve the rates or let's
2 consider whether this capacity is appropriate at this point.
3 It's a bigger job than it looks like.
4 DR. REISCHAUER: We've been worried about Medicare's
5 payment methodologies introducing distortions that affect
6 how much services are provided, what services are provided,
7 how factors of production are put together to produce those
8 services. Here we have a system which is radically
9 different from what's been operating in the rest of the
10 country and a 25-year period in which it's been operating.
11 It might be worth looking at what Maryland hospitals do and
12 see how different it is from what happens somewhere else to
13 see how worried we should be about these distortions. We
14 have a natural experiment here in a way.
15 MR. HACKBARTH: So, for example, look at investment
16 patterns and certain services that are high profit.
17 DR. REISCHAUER: Right. Is the incidence less in
18 Maryland than elsewhere? This is a system that applies to
19 all payers, not just Medicare so the impact of it, should in
20 a sense, be on steroids.
21 MR. MULLER: The way Craig and Jack have explain it and
22 the text indicates the hospitals -- for example, one of the

1 distortions, especially the one from last year, just to pick
2 the one from last year -- the hospitals can still do the
3 individual charges at their own discretion as long as the
4 average is within the average. So I agree with you it would
5 be interesting to see what has happened there but those
6 things could still occur.
7 DR. REISCHAUER: Cost-to-charge ratios haven't gone out
8 of sight so there aren't as great an incentive to produce
9 coronary bypass and things like that.
10 MR. MULLER: No, but it would be interesting to see
11 what the evidence is.
12 DR. REISCHAUER: Is the incidence lower or a not?
13 MR. ASHBY: I think it's worth thinking that there
14 really isn't the incentive to differ mark-ups as there is in
15 another system because you're going to get more or less
16 money from anybody by doing it, so the staff tell us that
17 most of the hospitals don't. Before we use the data we may
18 want to find out more about those practices, hospital to
19 hospital, before we just believe that that's the case.
20 MR. HACKBARTH: That's an interesting idea. We've been
21 alleging these things and think that the system is being
22 driven in a certain way and this is a natural experiment

1 testing some of those hypotheses.

2 MR. ASHBY: Could I just interrupt for a second? I
3 just wanted to take one moment to introduce Bob Murray who
4 is with us. He's the executive director of the agency, and
5 if anybody cares to ask questions of him now or after the
6 session that would be fine as well.

7 MR. MURRAY: I just wanted to say hello and thank you.
8 It's very much of an honor actually for me to be here and we
9 very much take seriously this role of being a laboratory.
10 With that, I'd be happy to answer any questions. Sorry I
11 was a few minutes late. I was in Annapolis dealing with our
12 legislature. Thank you.

13 MS. DePARLE: That was exactly my question and maybe
14 he's the right one to answer this. I found this paper
15 fascinating and I wonder if we know to what extent the
16 Maryland legislature becomes involved in the very detailed
17 away with each year's calculations and all that.

18 MR. MURRAY: It's somewhat surprising, but very little.
19 I think a lot of that is a function of the way our law was
20 crafted. Our agency was made independent from the
21 Department of Health and the Medicaid program. We have an
22 independent funding stream. We're funded by user fees on

1 all hospital admissions. There's been just this tradition
2 built up within the legislature -- it's lasted 30 years and
3 I hope it will last longer -- where they basically allow us
4 to tackle the problems, deal with the issues alone. I think
5 it's partially self-serving. They realize if we can't deal
6 with those issues then the problems are right in their lap
7 in Annapolis, and they would much prefer to have us work out
8 the issues because, as you well know, the issues related to
9 hospital reimbursement can be mind-boggling.
10 DR. MILSTEIN: How does Maryland or the metropolitan
11 areas within Maryland, how do they rank in the Dartmouth
12 Atlas on total Medicare spending per beneficiary and also
13 use of hospitalization for Medicare beneficiary? Is it a
14 so-called top decile low spending area, intermediate?
15 MR. MURRAY: It tends to be on the higher side. I
16 think it is a function of just medical practice on the East
17 Coast, maybe demographic issues. There's also Medicare is
18 paying a fair wage as well as Medicaid in Maryland because
19 of the all-payer system; they're contributing to
20 uncompensated care. It's a fair system in terms of covering
21 costs including uncompensated care. All those factors go
22 in, use patterns as well as rates, to put us on the higher

1 end of the spectrum.

2 DR. MILSTEIN: Could you just elaborate on how that
3 causality might work? I didn't follow it.

4 MR. MURRAY: The use patterns I think are obvious in
5 terms of the region that we're in here. Medical practice,
6 just the higher use rates, higher rates of hospitalization
7 and so on. In terms of the actual rates themselves, we do
8 have that extra provision for uncompensated care that
9 Medicare and Medicaid pay that does result in the rates
10 being a little higher. And we're covering costs. So I
11 think those things together, plus we do get a fair amount of
12 in-migration. Sometimes it's difficult to adjust for that
13 on a per capita basis exactly how much that contributes to
14 per capita expenditures being a little higher.

15 DR. MILSTEIN: Let me try to improve my question. A
16 fairer approach for making sure that uncompensated care was
17 paid for, I don't understand how that would increase or
18 decrease propensity to hospitalize or not hospitalize
19 Medicare patients.

20 MR. MURRAY: No, I don't think it does. I think it
21 just actually adds to the price, and the end results, per
22 capita expenditures, is quantity volume times price.

1 MR. HACKBARTH: Let me put it this way and see if I've
2 got it right. There's nothing inherent in the Maryland
3 system that would provide incentives to alter, improve, or
4 cause to worsen the patterns of care, per se. It basically
5 addresses the revenues coming into the institutions for
6 whatever pattern exists. So the patterns are driven by
7 factors exogenous to rate setting, and if Maryland is on the
8 East Coast with high use that's what's going to flow
9 through.
10 MR. MURRAY: Exactly, the two are unrelated. I'm
11 sorry, I didn't clarify that.
12 One issue you were talking about as I was walking in
13 was the propensity of Maryland hospitals to invest in
14 specialty services, high-end, high-tech, cardiology,
15 orthopedics, vascular. I think up until this year we still
16 had some distortions in the development of our case weights,
17 those averages that hospitals get credit for, that created
18 some of that same incentive in Maryland, albeit, I think
19 reduced relative to what has occurred nationally.
20 At the June meeting we adopted the use of internal
21 hospital relative weights along with the all-payer refined
22 DRGs, which we think will go a long way to reducing those

1 distortions. Because our weights were charged-based, and to
2 the extent we had certain hospitals like Johns Hopkins, the
3 University of Maryland, dominating those high-end services
4 and high-end cells you did get that same type of distortion.
5 We think we have removed that in the system.
6 MR. HACKBARTH: You're pointing to some relatively new
7 features of the Maryland system that are comparable to
8 recommendations that we made for refining the Medicare
9 system.
10 MR. ASHBY: Right. And I might add that the last of
11 our recommendations dealing with the funding of outliers has
12 already been in place in Maryland for a number of years as
13 well.
14 DR. KANE: I'm going to ask Arnie's question slightly
15 differently. Are your private sector premiums below
16 national averages because you've got Medicare and Medicaid
17 paying a much lesser differential between the private payers
18 and the public payers? Does that bring down your private
19 sector per capita?
20 MR. MURRAY: It does, without a doubt. It's resulted
21 in a big savings to the private sector over time because
22 they're not cost shifted against.

1 MR. HACKBARTH: Others?

2 MR. MULLER: Just by extrapolation some of the

3 incentives to move things out of the hospital setting

4 because of high charged based payers in the private setting,

5 what I infer therefore that you don't have that same

6 incentive so that we think it's just elsewhere?

7 MR. MURRAY: I think it is reduced. It's all on a

8 comparative basis though. There are certain service by

9 service where there are unregulated services, ambulatory

10 surgery, where it's far less expensive to do the care, you

11 get movement by payers from regulated services to

12 unregulated. But in general I think you're correct.

13 MR. DeBUSK: Let me ask a general question. Do you

14 think it's more economical to operate your system as

15 compared to the current system we operate under?

16 MR. MURRAY: I don't pretend to be an expert on the

17 financing and the administration of the national system. I

18 know a bit about it, of course, but one of the advantages of

19 our system is for a $10 billion industry I have 25 people

20 working for me and we have a budget of $4 million. It's

21 relatively modest. I think much smaller if you were to

22 scale it. That's because we operate -- I guess in a similar

1 way -- but we operate very much using formulas. It's not
2 detailed cost reviews, budget reviews year-to-year. But it
3 is a relatively cost-effective way of administering a
4 program. I don't know how to compare it directly to
5 Medicare and the nation but I would imagine it compares
6 favorably.
7 MR. DeBUSK: I believe we better pay attention.
8 MS. DePARLE: But you don't pay claims. You don't pay
9 hospital claims. I don't know but I wouldn't think that
10 necessarily is a useful comparison.
11 MR. MURRAY: It's hard to compare.
12 MS. DePARLE: I'm interested in following up on Ralph's
13 question. When you talked about regulated versus
14 unregulated -- I should know this, but is Maryland a CON
15 state when it comes to hospitals?
16 MR. MURRAY: Yes, it is.
17 MS. DePARLE: So that's one big difference. What about
18 ambulatory surgical centers, imaging centers?
19 MR. MURRAY: There are CON requirements but they're
20 relatively -- it's basically deregulated for CON for am-
21 surg.
22 MS. DePARLE: So the main thing is hospitals.

1 MR. MURRAY: Beds and specific services like open heart
2 surgery.
3 MS. DePARLE: How difficult, if you can characterize it
4 --
5 MR. MURRAY: It's fairly rigorous.
6 MS. DePARLE: That's my impression.
7 With respect to quality, Arnie and others have asked
8 some questions about this, but maybe it doesn't apply. Do
9 the Maryland hospitals have to comply with the MMA
10 requirement that to get the full marketbasket update they
11 report on the 10 quality indicators?
12 MR. MURRAY: We're exempt from that aspect of it but we
13 do still have hospitals that -- I believe there were three
14 hospitals that participated in the Premier Project and I
15 believe hospitals are submitting that data, although because
16 of the waiver and because of our system being separate
17 they're exempt from the implications on the marketbasket.
18 MR. ASHBY: I believe they are all reporting the
19 indicators.
20 MR. MURRAY: Yes, I believe they are.
21 MS. DePARLE: All the Maryland hospitals, are?
22 MR. MURRAY: Yes.

1 MS. DePARLE: Just voluntarily?
2 MR. MURRAY: Yes. But we are implementing our own pay-
3 for-performance initiative modeled very much on Medicare's
4 initiative, looking at the process indicators they've
5 adopted, and maybe with some enhancements or changes. They
6 advantage I think perhaps we have is it's all-payer, so we
7 have a closed-end system and there are some certain
8 advantages that come from that leverage.
9 MS. DePARLE: I guess I'd be interested in -- maybe
10 there's nothing that can be said from the data that we have
11 so far, but comparing Maryland hospitals versus some other
12 hospitals in terms of these quality indicators that we have
13 so far. I don't know whether, Jack, there's anything that
14 can be said about that or not.
15 MR. ASHBY: The analysis has not been done to date but
16 it certainly is an intriguing question, something we might
17 want to think about.
18 DR. MILSTEIN: Maybe you know this. Periodically,
19 Steve Jenks of CMS publishes statewide comparisons on a
20 variety including inpatient. How does Maryland rank, and
21 has that rank changed over the course of this waiver?
22 MR. MURRAY: I don't know what the most recent

1 information shows. I remember two, three years ago there
2 was an article in JAMA that he published and we were right
3 in the middle. I think we were 24th or 26th on those
4 indicators. But that was for data -- I don't know what time
5 period. But I do remember us being right in the middle.
6 DR. MILSTEIN: I think as part of our evaluation of
7 this it would be helpful to know what that rank was before
8 implementation of the waiver.
9 MR. MURRAY: I don't know that you've got data going
10 back --
11 MR. HACKBARTH: That's 1976. I'm not sure that they --
12 MS. DePARLE: I think he must be talking about the 2000
13 Medicare report, the first report on state-by-state
14 indicators, beta blockers at discharge, all that. I don't
15 think we would know that.
16 MR. HACKBARTH: You'd have to go back and do an
17 analysis, a re-analysis of --
18 MR. MURRAY: But you certainly could do an incremental
19 analysis and I'm sure we've improved. But still I think
20 with the implementation of pay-for-performance which will go
21 into effect in 2007 and 2008 that you'll see huge changes.
22 MR. HACKBARTH: Other questions, comments?

1 As Jack said at the beginning, I don't think that all-
2 payer rate setting is on the near horizon for the country as
3 a whole, nor would I individually advocate that. But I do
4 think that there is an opportunity to learn about some of
5 our hypotheses and whether things are working differently in
6 Maryland with a different set of incentives around specialty
7 services and the like, and also around some of the payment
8 refinements that we've talked about, wage index and a number
9 of others. So this has been helpful and interesting. Thank
10 you for coming.
11 MR. MURRAY: Absolutely. As I said, we'll make
12 ourselves available. We really enjoy sharing this
13 information. Not many people are interested in the United
14 States. A lot of people are interested in other countries
15 but not in the U.S.
16 MR. HACKBARTH: Thank you.
17 Okay, we are at our public comment period with the
18 usual groundrules which you know well but I'll repeat them
19 just for those who aren't familiar. I'd appreciate it if
20 you'd keep your comments brief and to the point, and if
21 somebody before you has already made the comment you don't
22 need to restate the whole thing, you can just say you agree.

1 MR. BAKER: Thank you, my name is Dale Baker. My
2 company is Baker Health Care Consulting from Indianapolis.
3 I work with hospitals throughout the country, both in
4 Medicare geographic reclassification matters and also with
5 hospitals and a lot of hospital associations in terms of the
6 Medicare wage index matters. I've got about three or four
7 issues I'd like to at least get out for your consideration
8 as you begin to look at this as some issues that I think
9 need to be looked at.
10 Approximately one out of every five hospitals is
11 reclassified in the country. One of the issues that your
12 fine staff brought out was on contract service data and
13 whether it was includable or not includable in the wage
14 index. It's always been includable for clinical contract
15 labor but has not been for non-clinical, for dietary and
16 housekeeping, et cetera. CMS is now collecting that data
17 with the full expectation that they'll actually be fixing
18 that issue in the next year or two as that data comes
19 online. I just thought that might be something you might be
20 interested in.
21 There are really three issued I'd like to bring to your
22 attention that you might want to think about as you design

1 these areas. The first one is occupational mix. As was
2 pointed out it's only been 10 percent implemented simply
3 because CMS realizes, as everybody else does, that it
4 doesn't work right. Let me just mention some of the
5 problems here.

6 First of all, it was legislated back in BBRA -- I
7 believe that was 1999 if I'm not mistaken -- before a lot of
8 the same issues -- they were trying to really improve rural
9 payment levels in comparison to urban payment levels by
10 putting in an occupational mix adjustment. In the MMA of
11 2003 it actually addressed that same issue of too low rural
12 rates in advance of any implementation of the occupational
13 mix adjustment. It's kind of an interesting dichotomy here
14 that the one didn't get implemented before the other was
15 legislated.

16 There is a huge gap between policy analysts and their
17 view of the workability of an occupational mix adjustment
18 and the people that have actually touched the data. From a
19 policy perspective it seems to make all the sense in the
20 world that once somebody has touched the data trying to put
21 all of the different variations into 20 categories, which is
22 how many CMS has in their current instrument, trying to put

1 20 different categories of hospital employees just doesn't
2 seem to make a lot of sense. Now the largest of those
3 20 categories is called all other. That all other category
4 comprises 51.31 percent of all of the employees in the
5 hospital. So the occupational mix adjustment is built on
6 less than 50 percent of the remaining hospital employees.
7 Now of the 19 categories that CMS surveyed there is nothing
8 in there for imaging. Where's Waldo?
9 In addition to that is after they came up with the 19
10 categories they collapsed them for the purposes of computing
11 the occupational mix adjustment into seven categories. The
12 significant collapsing is they collapsed registered nurses,
13 licensed practical nurses, nursing aides and orderlies, and
14 medical assistants into a single category, which to me
15 destroys the usability of any kind of an occupational mix
16 adjustment. I would want RNs broken out separately.
17 The other thing about that category when it's all
18 combined. it represents 37.89 percent of the 49 percent that
19 are included. So all the other categories in total include
20 10.8 percent of the total employees in a category. Anybody
21 who has looked at the actual calculations of this adjustment
22 and anybody's that's touched the data is appalled with this.

1 The results of this worse were supposed to help rural
2 hospitals. They ended up penalizing about one-third of the
3 rural hospitals in the country. The data as is currently
4 being used by CMS shows that the New York City hospitals
5 have a lower than average staffing level than hospitals
6 throughout the country. So the results of this whole
7 occupational mix thing are just unbelievable and I would ask
8 you to at least consider taking a look at the occupational
9 mix adjustment and whether or not it's workable. Even if
10 it's theoretically desirable, if it really works in the real
11 world. A lot of time and effort goes into preparing that
12 data.
13 A second issue I'd like to bring to your attention is
14 Section 505 the Medicare Modernization Act. Section 505
15 presents another border issue, which a number of you have
16 been discussing. What it basically says is that if your
17 county is bordering an area with a higher wage index and
18 over 10 percent of your workers, based on census data, are
19 computing into that higher area, that the hospitals would
20 get in this example, 10 percent of the difference between
21 the two wage indexes. It makes a lot of sense and it solves
22 a lot of borders issues.

1 The issue is the way it's been implemented by CMS. CMS
2 has implemented that base on the computation of the 2005
3 wage index, which they're not adjusting for the next fiscal
4 year for 2006 and 2007. So they're leaving it static for a
5 three-year period. Now obviously the census data is still
6 going to be there. If it's 10 percent, it's going to be 10
7 percent. We don't have any new data. But it should be
8 adjusted based on the differences between those two wage
9 indexes for the other two years of this three-year period.
10 I'm not sure I understand what CMS is not doing it, but
11 it creates anomalies where one wage index will actually be
12 above the other area wage index, and in addition to that
13 they add an out-migration adjustment on top of it. So it's
14 something that doesn't make any sense as it's been
15 implemented by CMS and I think it's something that would be
16 worthy of MedPAC to take a look at whether or not this
17 satisfies Congressional intent.
18 The third issue is what I would call the death spiral
19 issue. We may be seeing that right now. I haven't studied
20 this in detail but it's come to my attention in the last day
21 or two in Pittsburgh. Pittsburgh about four years ago,
22 closed a major hospital. I believe it's St. Francis

1 Hospital. The end result of that -- I'm guessing here
2 because I haven't studied it -- is there was a glut of
3 nurses on the market so nursing increases as a result of the
4 closure of a hospital did not go up.
5 So when that happens, and if the average hourly wage
6 nationally goes up 5 percent or something like that, the
7 wage index for Pittsburgh starts to go down because of the
8 closure of a hospital. As it goes down the Pittsburgh
9 hospitals have fewer dollars to pay their nurses and other
10 employees in future years and they can't keep up with the
11 rate of increase in the national average hourly wage, so you
12 end up with a spiraling wage index down from which, in
13 theory, there's no way to get around it. I don't know the
14 answer to that but as a look at wage index areas I think
15 this might be something you might want to take a look at.
16 Thank you very much.
17 MR. MASON: I'm Dave Mason with the American Physical
18 Therapy Association. I want to express our appreciation
19 both to the staff presentation and the Commission's
20 discussion on outpatient therapy spending. We're certainly
21 very encouraged to hear the discussion and the unanimity of
22 opinion about the problems caused by the Medicare therapy

1 cap. I would strongly reinforce the discussion that I think
2 the commissioners had about learning from that lesson and
3 not going into new alternatives or down new roads without
4 having much better data and a much better understanding of
5 physical therapy practice than was certainly apparent back
6 in 1997. We look forward to working with you to go down
7 that road and we share your frustration with the lack of
8 some of the current data, the lack of specificity in that
9 data.
10 You've recognized the potential of the impact of other
11 policies on the growth in outpatient physical therapy. Some
12 of the research that we're working on right now shows a
13 direct correlation, or appears to show a direct correlation,
14 in reduced billing for outpatient therapy services to fiscal
15 intermediaries and a corresponding increase in outpatient
16 therapy billings to Medicare carriers. We don't know if
17 that trend will extend over the 2004 data but there's enough
18 there to make us wonder if there are interactions of
19 inpatient and outpatient policies that may be having an
20 impact to drive up some of the spending that we're looking
21 at.
22 We appreciate, for that reason also, the idea of

1 forming an expert panel to look more deeply into some of
2 these issues and we would certainly volunteer ourselves, our
3 members, to participate actively in that effort and try to
4 help you identify additional data sources.
5 Along that line, we look forward to the opportunity
6 that we've already discussed with you and with staff to talk
7 more about an electronic medical records system that APTA is
8 developing which is known as Connect, and combined with a
9 patient assessment tool known as Optimal. The combination
10 of those two systems should greatly improve documentation
11 and reduce coding errors. It will also produce a database
12 of patient information that we think will be very helpful in
13 terms of risk adjustment and possibly moving towards pay-
14 for-performance standards.
15 So altogether we appreciate the discussion and we look
16 forward to working with you on this issue.
17 MR. WHITE: I'm Steve White with the American Speech
18 Language Hearing Association. Our members are speech
19 language pathologists and audiologists. You just heard from
20 Dave Mason, the physical therapists, and as you heard, 75
21 percent of the claims reflect physical therapy while about 7
22 percent reflect speech language pathology services. We may

1 be the smallest but we believe we're very vital in providing
2 those services as well. I just want to underscore what Mr.
3 Mason said. We really appreciate what you're doing and we
4 want to work with you as well and we'll help you with the
5 expert panel.

6 One of the things I wanted to point out today is that
7 we want to make sure that you understand that it isn't a
8 therapy benefit. There are three separate benefits,
9 physical therapy, occupational therapy, and speech language
10 pathology services.

11 We also want you to know that ASHA, like APTA, we have
12 an electronic system too that tracks outcome measures.
13 We've had this now in operation for about seven years. So
14 we can let you know my diagnosis -- I don't think we have
15 gait training in there, but we do have communication and
16 swallowing diagnoses included. So we can look at it across
17 provider setting, across age groups, and we can tell you the
18 level the patient was initially seen and how they did at
19 discharge.

20 Our members are now voluntarily submitting data to us.
21 There's no charge for this. We believe that this can be
22 really the foundation of a good pay-for-performance system.

1 So we concur with you that you do need data and we look
2 forward to working with you on helping you get those data.
3 Thank you.
4 MS. METZLER: I'm the third in the triumvirate, Chris
5 Metzler from American Occupational Therapy Association.
6 I'll echo everything that my colleagues have said about how
7 we appreciate that you are paying attention to this issue,
8 because despite the fact that you recognize it is, in the
9 scheme of things, a relatively small amount of money. But
10 as someone said, if we can't get a hold of what's going on
11 in this and we can't determine what we want this amount of
12 money to accomplish, then the rest of the system is probably
13 not well analyzed and structured either.
14 I want to mention a couple of things. I want to talk
15 about the data issue. There have been probably six or seven
16 studies that have been authorized, either by CMS or
17 elsewhere, OIG, GAO, looking at a solution to the caps. The
18 major problem that all of them have discovered is that the
19 data is inadequate. This partially results from the
20 streamlining that we've seen in the billing. We only have
21 the claims data that's available electronically. The claims
22 data can often be complicated, as you've seen. We might

1 have a diagnosis that doesn't really relate to the treatment
2 diagnoses for therapy.
3 We've worked on this issue going back to the late '90s
4 when the OIG was doing some investigations. There are
5 differences between what may be the presenting medical
6 condition and the issue that you're treating in therapy. So
7 we have to look at how we can gather that data more
8 effectively.
9 In the spirit of everything old is new again, in the
10 late '80s HCFA at that time contracted with BlueCross-
11 BlueShield of California which was at that time a Medicare
12 contractor, to develop a system of automated electronic
13 gathering of information about therapy, about the patient,
14 about the diagnosis, about the length of treatment. And
15 using an editing system that was to be implemented
16 electronically, and they developed this system, and
17 implemented it and they saved some money and it resulted in
18 some assurances of more appropriate care being provided, and
19 as well, knowing more about the patients, and what actually
20 occurred and why it was occurring.
21 But of course, at that time in the late '80s,
22 electronic recordkeeping was an anomaly. It was expensive.

1 It was burdensome. So providers said no, we can't handle
2 that. We can't fill out -- it was the 701 form. We don't
3 want to submit that electronically, that information, even
4 though you can use it to determine whether it's appropriate,
5 whether the length of the episode is appropriate, all those
6 things. That was not implemented. So we've lost a lot of
7 time in trying to improve the data systems.

8 I think we have to also look at not just electronic
9 edits but some of the methods that private insurance uses to
10 control therapy utilization. Those are things like prior
11 utilization, prior authorization, prior utilization review
12 and authorization, and for extreme cases, the high-cost
13 cases that were referenced earlier that show up in CORFs,
14 case management. That can't always be gone electronically.
15 It may be more intense, it certainly is more intense than
16 where Medicare is heading in terms of bill payment and
17 monitoring. But it is the way that it is done because
18 there's not a good handle on how you determine prospectively
19 what kind of therapy someone will need, because the
20 diagnosis is not the only factor.

21 That leads to the issue of outcomes, which we believe
22 is very important for us to look at. We've been doing a lot

1 of evidence-based work in occupational therapy, looking at
2 what the evidence shows in terms of what we can achieve.
3 But I think for the Medicare program we have to think about
4 what are the outcomes that we're expecting our dollars to be
5 achieving for beneficiaries?

6 And not only for beneficiaries individually but for
7 society. Thirty percent of the therapy services in Part B
8 are in SNFs. Those are long-term residents. That's long-
9 term care in effect. Is that we need to be providing? What
10 are the outcomes that we're expecting for those individuals?
11 They may be very different than the outcomes we're expecting
12 for a 55-year-old lupus patient who's on Medicare who gets a
13 full joint replacement in all of the knuckles of her hand.
14 The outcomes for her might be very different than what you
15 expect for an 85-year-old SNF patient. And we have to think
16 about the outcomes for that SNF patient in terms of some of
17 our other policies like OBRA and what we are expecting
18 nursing homes to achieve and provide for residents.

19 So we look forward to working with you and the ideas
20 that your staff has put forward, and the process to develop
21 a chapter I think will be very useful in this. It's been
22 ongoing for many years and I think it will continue to be

1 ongoing, but it is related to the larger purpose of what we
2 want our Medicare dollars to achieve for beneficiaries and
3 for society.
4 Thank you.
5 MS. ROCCO: Hi, my name is Holly Rocco. I'm here on
6 behalf of the National Association for the Support of Long-
7 term Care and also the American Healthcare Association, but
8 I primarily want to talk on behalf of the National
9 Association for the Support of Long-term Care.
10 Collectively, we absolutely would associate ourselves with
11 the other comments from the other therapy groups here today,
12 and with you all in agreeing that the data is inaccurate.
13 We've been looking at data for years now come as you all
14 have and as CMS has and we're coming to those similar
15 conclusions regarding diagnoses.
16 But we also wanted to agree with you all or express
17 support for a new payment system and also pay-for-
18 performance. We strongly support both of those. They
19 definitely go hand-in-hand. In order to get to a new
20 payment system we certainly do have more work to do looking
21 at the data. Certainly one of the things that might help
22 along that line is asking CMS and maybe even ASPE to look at

1 some sort of a common assessment across outpatient settings.
2 We think that that idea certainly has been out there.
3 Again I would echo all the other comments saying that
4 we would be happy to work with you all as well and to help
5 provide any information or assistance we can provide to your
6 efforts.
7 MR. HACKBARTH: Okay, thank you very much, and we will
8 reconvene at 9:15.
9 [Whereupon, at 4:36 p.m., the meeting was recessed, to
10 reconvene at 9:15 a.m., Friday, September 9, 2005.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, September 9, 2005
9:17 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
NICHOLAS J. WOLTER, M.D.

1 P R O C E E D I N G S

2 MR. HACKBARTH: We have two presentations this
3 morning, the first being on a mandated report due to
4 Congress on the effect of the oncology payment changes.
5 Joan, this is due when?

6 DR. SOKOLOVSKY: January 1.

7 MR. HACKBARTH: And then we have a panel on
8 quality measures in private plans. Joan, whenever you're
9 ready.

10 DR. SOKOLOVSKY: Good morning. Today I'll present
11 a work plan and some preliminary findings for the
12 Congressionally mandated study on the effects of Medicare
13 payment changes on chemotherapy services.

14 Recall that Medicare covers about 450 outpatient
15 drugs under Part B, including those administered by
16 physicians in their offices. The majority of spending for
17 physician administered drugs is to treat cancer.

18 As studies by MedPAC, GAO and others have shown,
19 before 2003 Medicare paid physicians at rates well above
20 their acquisition costs for physician administered drugs but
21 paid less to cover the costs of administering those drugs.
22 The MMA changed the way of Medicare pays for both the drugs

1 and drug administration services in a series of changes that
2 began in 2004.
3 I'll talk more specifically about those changes as
4 they occurred each year in a few minutes.
5 In the same law, Congress mandated that MedPAC
6 study the effects of these payment changes in a series of
7 two reports. One, that's due January 1, 2006, focuses on
8 oncology services. The second report, due January 1, 2007,
9 focuses on services provided by other physician specialties
10 who provide a significant amount of physician administered
11 drugs. This presentation today focuses only on the first
12 study for oncology services.
13 The payment changes began in 2004. Payment rates
14 for drugs were reduced, although the methodology for
15 calculating the rates remained the same. Where before
16 Medicare paid 95 percent of what's called the average
17 wholesale price or AWP, in 2004 the payment was reduced 10
18 percentage points to 85 percent of AWP. At the same time
19 payments for administering drugs to patients were increased
20 and a transition payment of 32 percent was added to the new
21 revised rates. That means that each time a practice billed
22 one of the new drug administration codes the payment was

1 then increased by 32 percent.

2 CMS estimated that the total effects of these
3 changes would be to increase Medicare payments for
4 oncologists.

5 Payment changes in 2005 were more far-reaching.
6 The payment changes included a new method for calculating
7 the payment rates for drugs called the average sales price
8 or ASP. Payment for drugs now is based on 106 percent of
9 ASP. Remember, we talked about this a few times before, ASP
10 is not a price that anyone can ask for. It represents the
11 weighted average of prices charged for a product in the
12 United States with some exceptions and it's based on data
13 submitted quarterly by pharmaceutical manufacturers net of
14 the rebates and discounts that they give purchasers. It
15 does not include any markups that are added by wholesalers
16 in the distribution chain.

17 At the same time as the payment methodology for
18 drugs was changed, transition payments were reduced to 3
19 percent. But about 14 new and revised payment codes for
20 drug administration were introduced.

21 In addition, CMS implemented a one-year
22 demonstration project to evaluate how chemotherapy affects

1 level of fatigue, nausea and pain that are experienced by
2 patients. All oncologists are eligible to receive $130 per
3 patient per day for asking chemotherapy patients three
4 questions on how they responded to treatment. CMS forecast
5 that this project would cost about $300 million and increase
6 total payments to oncologists by 15 percent.
7 Further changes are scheduled to occur in 2006.
8 The transition payments are scheduled to be phased out and
9 this would mean a reduction of 3 percent for drug
10 administration codes. Additionally, CMS has not yet
11 announced whether it will renew or modify the demonstration
12 program that we just talked about.
13 And finally, the MMA calls for the implementation
14 of a new methodology called the competitive acquisition
15 program or CAP. Under this program vendors, who would be
16 like wholesalers or specialty pharmacies, would bid to
17 become Medicare providers of Part B drugs. Each year every
18 physician or practice would choose in January whether to
19 continue to purchase and bill for drugs through Medicare or
20 receive their drugs through one of these Medicare designated
21 vendors. Vendors would purchase and dispense the drugs to
22 physician offices on the basis of prescriptions written by

1 physicians for their individual Medicare patients. Medicare
2 would pay the CAP vendor directly and the vendor would bill
3 patients for the required copayments.
4 However, CMS has delayed implementing this program
5 in response to comments by both vendors and physicians on
6 the proposed rule and the earliest time it may be
7 implemented would be July of 2006.
8 In looking at our mandate and the key issues that
9 are raised by the payment changes, two issues really
10 dominate. One is whether access to care has been affected
11 by the changes; and secondly, has quality of care been
12 affected. When the MMA was passed some oncologists reported
13 that they might have to send their Medicare patients to the
14 hospital for chemotherapy -- hospital outpatient I should
15 say. Currently, most chemotherapy is provided in physician
16 offices. A significant shift in site of care could create
17 access problems for beneficiaries if hospitals do not have
18 the capacity to meet a higher demand.
19 In addition, costs are traditionally higher for
20 beneficiaries and the Medicare program in hospitals for
21 chemotherapy.
22 Beneficiaries without supplemental insurance, so

1 they have nobody to pay the 20 percent copayment,
2 beneficiaries that are dually eligible for Medicare and
3 Medicaid, and patients receiving expensive therapies are the
4 patients that have been particularly cited as possible might
5 be shifted to hospitals.
6 This Congressional report presents a really
7 significant challenge for us. Because the legislative
8 changes have not yet been fully implemented, MedPAC's
9 ability to analyze the impact will be limited. In addition,
10 we don't have Medicare claims data for 2005 although we are
11 working very hard with CMS trying to get partial year data.
12 The 2005 changes are likely to be more significant than any
13 of the changes in the previous year. Given these
14 limitations, we are approaching the study from a number of
15 different directions, trying to get at these issues. I'll
16 talk about a couple of these today.
17 First, we're looking at Medicare claims for
18 chemotherapy drugs and chemotherapy drug administration
19 services. We're looking at claims from 2002 through 2004.
20 The bottom line is that the volume of chemotherapy services
21 increased throughout this period in both physician offices
22 and hospital outpatient departments although more quickly in

1 physician offices.

2 Remember here that other factors besides Medicare
3 payment changes have affected the growth in services. Use
4 of chemotherapy has been affected by new technologies and
5 new treatment guidelines. These changes are likely to
6 continue to affect Medicare spending for chemotherapy. For
7 example, in the last couple of years a number of very
8 expensive new drugs have been introduced. One of the drugs
9 receiving the most attention, Evastin, oncologists have told
10 me that it costs about $12,000 for a round of therapy with
11 Evastin every two weeks.

12 In addition, treatment guidelines that call for
13 more chemotherapy either before other forms of treatment
14 like surgery or after other forms of treatment, have also
15 been introduced.

16 I want to show you some preliminary results from
17 this claims analysis. These analyses were carried out by
18 Chris Hogan of Direct Research. It's still preliminary and
19 the numbers are subject to change. It's very hard to
20 compare physician and hospital outpatient because the
21 payment systems are so different and because both of the
22 payment systems were undergoing changes during the same two-

1 year period. So coding changes really make both the
2 physician and hospital side comparison very difficult. It's
3 really suggestive, but the table represents our attempt to
4 put both drugs and services on a common scale.
5 Counts are simply measures of the number of times
6 codes in the category of chemotherapy drugs and drug
7 administration were billed. The second row, which I think
8 is more indicative of what's going on, measures changes in
9 the volume and intensity of services for drug
10 administration. So it's RVUs at 2004 prices held constant,
11 and volume and changes in drug mix, also in constant prices,
12 for drugs. And here drug mix means if you're substituting
13 new, more expensive drugs, for older drugs, or on the other
14 hand if some drugs become available generically and the
15 price goes down, the intensity would go down there
16 It's important to note that this data only goes up
17 to 2004 and so does not take into account the changes of
18 2005. As I've said, we're more hopeful than when I sent you
19 the mailing material that we will have some 2005 data.
20 This data indicates that before and after the
21 Medicare payment changes, the volume and intensity of
22 chemotherapy drugs and services provided to Medicare

1 beneficiaries rose in both settings, physician offices and
2 hospital outpatient departments. And we see no shift in the
3 aggregate in site of care. We intend to look further at
4 this data to see if even, if there was no shift in the
5 aggregate, if particular types of beneficiaries,
6 particularly dual eligibles, did experience a shift in site
7 of care. Unfortunately, claims data can't tell us if
8 beneficiaries have supplemental insurance so we won't be
9 able to measure the effect of payment changes for
10 beneficiaries without supplemental coverage.
11 As another part of our analysis, in 2004 we
12 conducted site visits and five states or metropolitan areas
13 to learn how chemotherapy was delivered in different types
14 of practices around the country. In some cases we focused
15 on a single metropolitan area. In others we visited
16 practices located throughout a state.
17 We visited practices in Northern New Jersey, in
18 the state of Iowa, in the metropolitan areas of Seattle and
19 Atlanta, and throughout the state of New Mexico. In
20 physician offices we met with oncologists, oncology nurses,
21 practice administrators and pharmacists. In addition, in
22 hospitals we met with the relevant personnel within

1 community hospitals, university hospitals and cancer
2 specific hospitals. We also met with representatives from
3 local health plans.
4 Currently we're conducting follow-up interviews
5 and in some cases returning to these sites. Here we're
6 asking practices to evaluate how the payment changes
7 affected them. We're also asking them about ways in which
8 Medicare could both measure and provide incentives for
9 quality care for cancer patients. Because these visits are
10 ongoing, I don't want to say too much about what we've heard
11 and preempt those people who have agreed to have us visit
12 them and haven't yet a chance to have their say.
13 A third part of the analysis focuses on drug
14 pricing. We've purchased commercial data on prices for the
15 top Part B drugs used by oncologists for a period ranging
16 from the last quarter of 2004 to the third quarter of 2005.
17 Although this data does not include the rebates that
18 purchasers received from manufacturers, and so cannot tell
19 us directly whether oncologists are purchasing drugs at the
20 Medicare rate, they do allow us to look at price trends over
21 time and variation in the prices negotiated by different
22 purchasers. We haven't completed this analysis but the

1 methodology of the average sales price leads us to certain
2 hypotheses.
3 In cases where there are competing drugs that are
4 recognized by physicians as clinically equivalent, we would
5 expect the ASP system to result in lower Medicare payment
6 rates over time. For other drugs, we would expect the ASP
7 methodology to result in less variation in the prices
8 different purchasers pay. That means that those purchasers
9 who are accustomed to big discounts might pay more and those
10 customers who generally do not get very good prices might
11 get better prices under this system. This is because
12 manufacturers would know that if they gave large discounts
13 to some purchasers it would result in lower Medicare payment
14 rates in the following quarter.
15 Conversely, and remember these are drugs where the
16 market is somewhat limited, conversing manufacturers would
17 expect that if they charged high prices to some purchasers,
18 those purchasers might not be able to buy their products at
19 the Medicare payment rate and simply might not buy them. We
20 will examine whether or not the data confirm these
21 hypotheses or if in fact we see other patterns.
22 A number of the other studies that we're doing,

1 I'll just say very briefly, we're doing focus groups of
2 beneficiaries designed to ask those beneficiaries receiving
3 chemotherapy whether they've experienced any access problems
4 in the past year, whether the site of service for their care
5 has shifted, or whether they've noticed any other
6 significant changes.
7 We're interviewing wholesalers and people at group
8 purchasing organizations to get at whether drug purchasing
9 and distribution patterns have changed because of the new
10 Medicare payment rates. And we're talking to stakeholders,
11 both physicians but also specialty societies, talking about
12 particularly the ways in which Medicare could incentivize
13 quality care for chemotherapy.
14 Another work that's ongoing is the Marshfield
15 Clinic is looking at the costs of treatment for chemotherapy
16 patients, and we're hoping that that study while inform our
17 work.
18 These represent very broad directions that you
19 might want to have us develop in terms of policy options.
20 One, of course, as I've been saying, is to create incentives
21 to improve quality of care for chemotherapy patients.
22 The second one is if we, in fact, do discover that

1 there are certain beneficiaries, particularly because of the
2 high cost of drugs, who are having problems paying their
3 copayments then we might want to look at some kind of
4 public-private partnership to help them with cost sharing.
5 And the third of broad direction is to further
6 refine and standardize the ASP methodology.
7 I'm looking forward to your suggestions and what
8 other information you think you might need to address these
9 issues.
10 DR. SCANLON: A couple of comments. There are so
11 many aspects to this study. One is on the issue of what's
12 going to happen with the prices that manufacturers charge.
13 I think, in thinking about the hypotheses, it's important to
14 remember that the price that Medicare is paying is going to
15 the physician and that historically one of the concerns was
16 that spread between AWP and the price that manufacturers
17 charge and how that was being used to potentially influence
18 decisions.
19 Now if it wasn't having a big effect in terms of
20 the demand that physicians may have for a drug,
21 manufacturers might not change their prices for anybody
22 because the manufacturer can still receive the same

1 revenues.

2 If there is a need to, in some respects, induce
3 physicians to use your drug by affecting how much Medicare's
4 going to pay, then the kinds of scenarios that you've laid
5 out might take place. I won't be shocked if it doesn't turn
6 out that the original hypothesis is supported, because it
7 may be more consistent with that idea that it didn't have
8 that much of an influence on the choice of drugs.

9 The issue that you raise about the cost sharing
10 that might be involved in these very expensive drugs, I
11 think opens us up to a bigger question which is the
12 unlimited liability that exists for Medicare beneficiaries
13 right now for a variety of different conditions. And I
14 think this would just be one example of how your potential
15 cost sharing obligations are unlimited in Medicare. There's
16 no catastrophic cap and we should think about -- not a
17 recommendation with respect to only this service, but think
18 about it in that broader context.

19 DR. KANE: Again, as a newcomer here, it would be
20 helpful to me to kind of understand why the payment changes
21 were put in place to begin with and then how we know whether
22 that was worth it. It sounds, from what Bill just said,

1 that one of the reasons was to be sure that the physician's
2 choice of the chemotherapy drug was the appropriate one
3 medically and wasn't influenced economically. I don't see
4 any effort to ascertain that yet.
5 It sounds like we're mostly studying how prices
6 are changing and whether access is affected, which is also
7 obviously important. But what were the goals of the policy
8 changes to begin with? And are we looking into whether
9 those are being achieved? Or do we have a way to do that?
10 DR. SOKOLOVSKY: The goal of the payment changes,
11 as Bill was saying, was Medicare spending for Part B drugs
12 was growing at 25, 35 percent per year. As a GAO study
13 found and a number of other studies found, one of the main
14 reasons for that was that the spread between AWP and what
15 physicians were really paying was growing over time. And it
16 was growing because that was a way to market the drugs.
17 On the other hand, as physicians were saying and
18 as studies showed, the payments for drug administration were
19 not covering the costs. The spread was not just a spread
20 but also covering other factors.
21 So the main reason for the change was to stop that
22 trend in payments, to try to pay for what physicians did

1 rather than pay too much for one side and have it not be
2 covered.
3 On the other hand, as far as the choice of drugs
4 is concerned, that is something that we are talking about in
5 our site visits. When I report to you in more detail on
6 that site visit, that is something that we discussed quite a
7 bit with the physicians about how choice of drugs is
8 affected by these payment changes.
9 DR. SCANLON: Having lived through that GAO study,
10 this issue extended beyond oncology. It was all of the Part
11 B drugs. The basic problem is that average wholesale price
12 is a misnomer. It's not a price, it's not an average. It's
13 a number that's reported and became the basis for Medicare
14 payment. And what we discovered was that, in terms of the
15 Part B drugs, there was this huge gap between what
16 manufacturers were selling the drugs for and what they were
17 reporting as AWP.
18 For some of the inhalant drugs it was even worse
19 than it was for the chemotherapies. There was something
20 like maybe an 80 percent gap between average wholesale and
21 what the drug was actually selling for.
22 In terms of the administration been underpaid, I

1 think it's important that we remember or identify the fact
2 that there were some problems with how CMS, or HCFA at the
3 time, was calculating the payments for administrative
4 services, chemotherapy administrative services. But they
5 were relatively modest compared to what you might think of
6 as an underpayment.

7 It was an issue that all physician services, in
8 terms of practice expense, are not paid at their average
9 cost. We hinted yesterday at the difference between average
10 and marginal cost. Because of budget neutrality, there's
11 about a 30 percent discount on practice expense costs in
12 terms of setting fees. And that matters in terms of
13 chemotherapy administration because there's no physician
14 component. There's no work element to those services so it
15 has a bigger impact there.

16 But at this point, chemotherapy administration
17 services are being treated differently than other services
18 that don't have a physician component. So in terms of
19 equity across physician specialties, there's a question that
20 could be raised.

21 MS. DePARLE: First, I thought Nancy's question
22 was a very good one. I was looking back. Her point was

1 raised at times during the debate over the pricing, that the
2 inappropriate incentives created by the AWP pricing
3 methodology did lead some clinicians to prescribe the wrong
4 drugs or to make decisions they might not otherwise make.
5 I don't know whether there's any way of getting at
6 that but I hope we can at least, if not, make the point that
7 we think that's an issue or that perhaps it would be raised
8 in your site visits. You might ask some questions about
9 that, that maybe we'd get at least some data.
10 DR. MILLER: Joan, you have actually been having
11 discussions about how the current pricing system is
12 potentially affecting regimens of care that are provided.
13 She did it in her initial visits and she plans to follow up
14 on this. So I think, at least in the site visit work, this
15 will be discussed.
16 MS. DePARLE: Because I know, from talking to
17 representatives of beneficiary groups, that is something
18 they were very concerned about and continue to be concerned
19 about actually. So it would be worth seeing if there's
20 anything we can say about that.
21 DR. REISCHAUER: Can I just have a footnote on
22 that? Because it's not just inappropriate because you could

1 have two drugs that are equally effective and one cost 10
2 times what the other does or has an AWP 10 times what the
3 other one does. And there's an incentive to use the more
4 expensive drug.
5 MS. DePARLE: Lupron and Zoladex or whatever it
6 was. There's that issue, as well.
7 I have a slightly different question about this.
8 I don't know that this is exactly covered by our mandate,
9 but some other payment changes -- I would characterize them
10 as changes, some might not -- that have occurred over the
11 last couple of years with respect to oncology. I'm
12 interested whether in our site visits that you're going to
13 continue to do or the interviews you're going to continue to
14 do you can get at this, which is the issue of off label use
15 or prescribing of chemotherapy drugs.
16 Just by happenstance, the father of a good friend
17 of mine, the friend called me. He had been prescribed
18 Evastin for a form of cancer for which it is not at this
19 point labeled. And as everyone knows, most oncology drugs
20 are labeled for one thing. But oncologists tell me that in
21 many cases the standard of care is to quickly diffuse to
22 other cancers to see if it will work.

1 And in this case at least one of the carriers was
2 saying no, we will not pay for that cancer. There's been a
3 bunch of changes that have occurred in the last year really,
4 some of which revolve around the use of registries for the
5 colorectal sets of cancer drugs. But also, it's my
6 understanding that there has been a change in the emphasis
7 on enforcing the off label usage constraints, which I don't
8 recall being an issue when I was there. But now suddenly it
9 is and I'm hearing more and more about that from beneficiary
10 groups.
11 So that isn't exactly your mandate, but it is how
12 have Medicare payment changes changed things for
13 beneficiaries. I'd be interested if you can find out more
14 about that.
15 DR. SOKOLOVSKY: This actually is something that
16 we have been talking about even since last year's site
17 visit. It's a very big issue for the oncologists that we
18 visit. Especially there's a lot of variation between local
19 carriers and the extent to which they enforce the off label
20 or what evidence you need to provide.
21 And sometimes this is a situation where people are
22 being sent to the hospital outpatient more because an

1 intermediary is covering the drug in the hospital where the
2 carrier is not covering it in the physician offices. So
3 this is where we're seeing a lot of that kind of variation.
4 MS. DePARLE: My friend was sent to both places
5 and in the hospital the billing office came up and said even
6 though we would have covered this last year, now we're being
7 told we can't for your cancer and give us $10,000 for each
8 round of treatment every two weeks or whatever.
9 So again, we've talked in this room about criteria
10 for coverage and some things may be covered and other things
11 may not and that's how it is, but this was a pretty harsh
12 result for my friend's father. I'm just interested in how
13 much that's going on out there.
14 DR. WOLTER: I think one of the contextual things
15 going on here is that oncology is a specialty where for a
16 physician income, an usually high portion of that income is
17 related to the profit of these drugs. That was particularly
18 true under the old system. I mean, really in excess of 50
19 percent in many cases.
20 And that's a problem, I think, in and of itself.
21 You might raise the question philosophically if it would be
22 better to be sure that the work the physician is doing is

1 recognized appropriately and have all of the drug issues
2 handled by a third party rather than flowing through sort of
3 an individual. Because I think it just raises issues. And
4 it's hard to get at this but it would be interesting to know
5 where have physician incomes gone under these changes.
6 I've heard many of the cries about how access to
7 care, et cetera, will be impaired. But I think there's lots
8 of room in this equation yet for everybody to still do well
9 and for patients to get good care.
10 The other question we should ask ourselves, as we
11 always do, is should we try to steer payment for drugs in
12 Part A and Part B to be more similar rather than more
13 different so that we don't have some of these difference.
14 That's a good point, Nancy. I think that the coverage
15 issues, too, should be more similar, rather than more
16 different.
17 I think we have an unusual context here and there
18 are not that many specialties where the portion of your
19 income that comes from the profit of a supply is such a
20 driving factor.
21 DR. MILLER: Joan, this is probably not correct,
22 but to his point about having the physician in or out of the

1 transaction in the purchasing of the drug, am I right that
2 the CAP program would take the physician out of that
3 transaction?
4 DR. SOKOLOVSKY: That is the goal of the CAP
5 program. Again, there are problems with how it would be
6 implemented.
7 DR. MILLER: That's right. And so a thing that we
8 could, along those lines, try and look a little more
9 aggressively at is is that a mechanism if improved? Or are
10 there different mechanisms altogether that might get at what
11 you're tried to articulate?
12 DR. SCANLON: It's not the goal in the sense that
13 we're going to use the CAP to substitute for ASP plus 6
14 percent. It's meant to be a safety valve for physicians
15 that can't buy the drug at a low enough rate that they want
16 to accept except ASP plus 6 percent for the reimbursement.
17 So it may be a vehicle for a policy change that's
18 consistent with what Nick said but it's certainly not going
19 to happen overnight because they may be doing fine under ASP
20 plus 6 percent.
21 DR. MILLER: Definitely not going to happen
22 overnight. I mean, the regulations decided not to go

1 forward with it because they weren't getting enough people
2 to come into the program. I'm speaking in very general
3 terms because I don't have the facts probably right and I'm
4 waiting for Joan to intervene here and get them right.
5 But the point is, could we look at that? And if
6 fixed, would it begin to work a little bit better?
7 MS. DePARLE: But didn't that come about as a
8 compromise because some in Congress wanted it to move to
9 exactly what Nick postulated, which is to get the doc out of
10 the equation? Others felt that no, we want to keep them in
11 and maybe we can just change the pricing around, is what I
12 recall.
13 DR. MILLER: I still think there was a competition
14 element there that people were pushing, as well. Again,
15 Joan?
16 DR. SOKOLOVSKY: The theory of the CAP program, as
17 it was originally proposed, was more about the competition
18 among vendors bringing down the price of drugs. On the
19 other hand, as it was passed, it was sold more as a safety
20 net for those providers who were not getting good prices.
21 But as it came about, the way the regulation was
22 proposed, neither the physicians nor the potential vendors

1 were happy with the way it was set up.

2 MS. DePARLE: Does the fact that we're not moving
3 quickly to implement the CAP, at least on the schedule that
4 was set forth, does that mean that ASP plus 6 is adequate?
5 The oncologists think it's okay? They weren't coming in to
6 join up with the new program?

7 DR. SOKOLOVSKY: I would say, without kind of
8 preempting where the site visits are going that haven't
9 taken place, and particularly the non-oncologists that we've
10 been talking to, who you would think this would be more
11 important to them because it's less of -- they have less
12 experience purchasing drugs.

13 What they felt was that the way it was proposed it
14 was going to cost them more money than actually purchasing
15 the drugs because of the different kinds of billing
16 requirements and inventory requirements and various other
17 things in the rule, many of which you could understand where
18 they came from in terms of problems of fraud and abuse. But
19 the idea that a physician had to write an individual
20 prescription each time was a concern for them.

21 In fact, the truth is again that we haven't found
22 any of those people thinking oh, this will work for us the

1 way it was proposed.

2 DR. NELSON: Joan, am I correct in my impression

3 that the out-of-pocket liability for beneficiaries who don't

4 have Medigap insurance would be greater if they received

5 their treatment in the OPD rather than the physician's

6 office?

7 DR. SOKOLOVSKY: Yes.

8 DR. NELSON: Is that a substantial difference?

9 DR. SOKOLOVSKY: It always has been. Because of

10 the payment changes on both sides we don't have good numbers

11 now to really compare them. But my assumption is it still

12 would be true. Private payers, the health plans that I've

13 been talking to, and they have experienced this issue more

14 directly and earlier because some of them tried to reduce

15 their rates in previous years and did see people being

16 shifted to the hospital. They said it costs them two to

17 three times as much.

18 DR. NELSON: I think that's a real concern and

19 something that we got to continue to track very carefully

20 because after all, we're concerned about the beneficiaries

21 around here. If they can't afford treatment that might save

22 their life because of the substantial difference in out-of-

1 pocket costs, that's a concern for us.

2 MR. MULLER: Joan, one of our recurring themes is

3 just the pace and costs of technology, technological change.

4 You noted that some of the new drugs, especially biologics,

5 are quite expensive. How are we going to capture that

6 underlying change in the cost of the mix of drugs? You're

7 looking at the change from AWP to the ASP pricing. And as

8 you noted, there will be a lot of movement there.

9 But just the underlying real cost is also going up

10 quite a bit, in addition to these kind of how you evaluate

11 markup changes. How are we going to be capturing that?

12 Because certainly a number of us are seeing that, the ones

13 that are coming down, especially some of the more targeted

14 biologics, are quite expensive. So how do we capture that?

15 DR. SOKOLOVSKY: That is part of what we were

16 trying to talk about in terms of drug mix, where you look at

17 a regimen. And one regimen costs X amount for say a lung

18 cancer patient. And then you introduce this new drug and

19 the cost is very much higher. Again, we can't separate

20 markup because we don't really know what the actual cost is.

21 But we do know that these drugs are very much more

22 expensive.

1 When I look at the top 20 drugs for Part B drugs,
2 every year we've been looking at them every year from 2002
3 now through 2004, and hopefully we'll have 2005. And we see
4 a change. And the change is consistently the newer drugs
5 are quickly moving into that top 20. It's not because
6 they're being used so much more but because the spending is
7 so much greater.
8 MR. MULLER: My guess is that's a double-digit
9 accelerant and beyond. So I think keeping our eyes on that,
10 like we did on some other advances in technology, is
11 important.
12 MR. SMITH: The technology itself.
13 MR. MULLER: I call it technology but I'm lumping
14 it into imaging, et cetera. But it's basically -- it may be
15 the wrong label but certainly there's an underlying change
16 going on. There's an assumption that the efficacy is
17 greater. It's obviously something that has to be shown in
18 trials and so forth, but it is accelerating quite a bit.
19 DR. REISCHAUER: I have on the list myself, myself
20 Dave and Arnie. And we're going to cut it off at that
21 point, because of the panel that we have coming.
22 First, just a comment to Nancy about how does this

1 come about. Suboptimal policy is often not sufficient to
2 get legislative change in this area, and especially
3 legislative change that is proposed to be budget neutral.
4 So you have to ask yourself what else was going on?
5 You often need a poster child in which the media
6 and the participants can fine an outrage in. In this
7 particular case, as we were told by the Joan's analysis in
8 previous years, there were some cases in which the
9 coinsurance amount charged to the beneficiary exceeded the
10 acquisition costs to the physician, which made this in a
11 sense sort of extremely egregious.
12 Joan, I was wondering whether in Chris' analysis
13 when it comes forward we're going to be able to
14 differentiate between the growth of RVUs and the growth of
15 drugs? You said they were lumped together in these
16 measures.
17 DR. SOKOLOVSKY: We have them separated.
18 DR. REISCHAUER: So you do have them separated.
19 And then whether there were some drugs, because of
20 the recovery time, are largely administered in outpatient
21 settings rather than in doctor's offices and they have
22 different price characteristics than the average for

1 doctors, whether that could skew the analysis at all?

2 DR. SOKOLOVSKY: We're no longer finding evidence

3 of that. There are some that require such long infusions

4 that they're actually inpatient and those wouldn't appear at

5 all.

6 DR. REISCHAUER: Just correct me if I'm wrong,

7 going forward we're going to have a situation where if

8 you're receiving a Part B drug that's very expensive, you

9 have no catastrophic protection. If it's a Part D drug

10 that's very expensive, you do have protection. And there's

11 a question whether a system like that is sustainable over

12 the long run politically. I kind of think it isn't. That's

13 well beyond where we're going here but it might be something

14 that in the long run we look into how you coordinate these

15 programs.

16 Next we have Dave.

17 MR. SMITH: Alan and Bob have largely raised the

18 question that I wanted to, but I think we all around this

19 table have some things that we just have not ever figured

20 out and try to be quiet. And I am generally on the oncology

21 stuff.

22 But why don't we know, Joan, or if we know why

1 can't we use the actual acquisition price? We've got all of
2 these hypothesized prices or notional prices, but can't we
3 get at the real price? And if we could, would that help us
4 figure out how to deal with some of the questions that Nick
5 raised earlier about what share of the physicians' income is
6 related to some manipulation we do of the price? Do we know
7 actual prices?
8 DR. SOKOLOVSKY: The average sales price
9 methodology is designed to get as close to that as they've
10 figured out how to get so far. But on the other hand,
11 that's proprietary.
12 What we're buying does not include the rebates,
13 which are quite significant. So looking at that, it doesn't
14 really answer that question for us.
15 DR. MILLER: But the other angle on this, isn't it
16 Joan, is that to go out and get the acquisition costs you
17 have to go into the physician's office drug by drug and
18 start getting that information. And then you start running
19 into real burden issues.
20 DR. SOKOLOVSKY: That's absolutely true. And even
21 if you did that, you wouldn't necessarily really get the
22 acquisition price because many rebates are -- they're look

1 back.

2 DR. MILLER: After the period, right.

3 DR. MILSTEIN: In trying to forecast forward what
4 would be the potential adverse consequences of such a change
5 in policy, you've done a nice job of outlining what those
6 might be and how we might study those. There were a couple
7 of other, I thought, opportunities to study potentially
8 unintended undesirable behaviors that such a policy might
9 induce that I just thought I might throw out on the table
10 for your consideration.

11 The first would be, we've asked and asked about
12 quality of care. And as I understand it, based on budget
13 practicality and limitations and guidelines in this area,
14 we're going to focus on beneficiary interviews. If you
15 decompose potential quality threats associated with this
16 policy change, you're really following two buckets: policy
17 change affecting choice among treatment options in ways that
18 adversely affect quality. And I'll think about it some more
19 but on the fact of it I don't see a good way, an economical
20 way of getting at that.

21 The second would be that this policy change, to
22 the degree it constrained the amount of money available to

1 support treatment, induced cutting of quality corners in
2 treatment administration. And for most of these therapies
3 there are -- one can infer back as to recommended so-called
4 safe practices in administering these. These are both
5 generic and actually were defined by the National Quality
6 Forum, in some cases for inpatient setting, but many of them
7 apply to an outpatient setting.

8 And of those -- let's call them safe cancer
9 treatment administration practices -- there is a subset of
10 them that are observable via the patient.

11 If patient interviews is the outside limit of our
12 budget capability, in terms of testing the question of
13 whether not quality has deteriorated, it seems to me that
14 systematically thinking about what those safe practices are
15 in administering both cancer therapy in general and some of
16 these treatment options specifically, then just sort of home
17 in on the subset of those things you could reasonably rely
18 on the patient to observe, might be a way through more
19 focused patient interviews getting more structured
20 information on whether quality was adversely affected.

21 DR. SOKOLOVSKY: These are also the issues that
22 we're discussing in the site visits with the physicians.

1 These are the issues that are coming up.

2 DR. MILSTEIN: I guess my suggestion implies were

3 the structure of the questions based on an analysis of

4 current recommended safe practices that have been published

5 with respect to either particular cancer therapies or any

6 cancer therapy administration?

7 DR. SOKOLOVSKY: It's clearer in terms of the

8 mixing safe practices for mixing up of drug administration

9 and we've been able to talk about those kinds of things. In

10 the other side, it's much harder to find anything, which is

11 why we're talking so much to physicians and to specialty

12 groups and why we might want to come to you with some ways

13 of collecting data so that we can actually define those

14 things.

15 MR. HACKBARTH: Okay, thank you. Good job, Joan.

16 Next we have a panel of experts on measuring

17 quality in private plans. Niall, you'll do some

18 introductions.

19 Welcome to you all and we very much appreciate

20 your spending time with us.

21 MR. BRENNAN: Thanks, Glenn.

22 In the March 2004 report, the Commission concluded

1 that Medicare should introduce pay for performance
2 incentives to provide high quality care in the MA program
3 because of the importance ensuring the provision of high
4 quality care to Medicare beneficiaries and the existing
5 availability of an accepted set of quality measures for MA
6 plans.
7 Over the course of the fall we intend to further
8 explore the issue of quality measurement in MA plans,
9 drawing on both quantitative analysis and views from the
10 field.
11 Today I'm pleased to present to you a panel of
12 experts who will share with you some of their views on
13 quality measurement in MA plans. Our invited speakers are,
14 in order of appearance, Jack Ebeler from the Alliance of
15 Community Health Plans, Dr. Samuel Nussbaum from Wellpoint,
16 Incorporated, and Peggy O'Kane from the National Committee
17 for Quality Assurance.
18 I'm just going to make a few brief biographical
19 introductory marks for our speakers.
20 Jack Ebeler is President and Chief Executive
21 Officer of the Alliance of Community Health Plans. He was
22 appointed to this position in 2001. Prior to joining ACHP,

1 Ebeler was Senior Vice President and Director of the Health
2 Care Group at the Robert Wood Johnson Foundation, the
3 nation's largest philanthropic organization devoted solely
4 to health and health care.
5 Dr. Samuel Nussbaum is Executive Vice President
6 and Chief Medical Officer for Wellpoint, Incorporated, where
7 his principle responsibilities include serving as chief
8 spokesperson on medical issues, guiding the corporate vision
9 regarding quality of care and its measurements, leading
10 efforts to assess cost of care performance, and developing a
11 strategy to foster further collaboration with physicians and
12 hospitals to strengthen and improve patient care.
13 Our last speaker is Peggy O'Kane, who is the
14 President and founder of the National Committee for Quality
15 Assurance, an independent nonprofit organization whose
16 mission is to improve health care quality.
17 Under Ms. O'Kane's leadership, NCQA has developed
18 broad support among the employer and health plan
19 communities. Most Fortune 500 companies will only do
20 business with NCQA accredited health plans, and nearly all
21 use Health Plan Employer Data and Information Set data or
22 HEDIS data to evaluate the plans that serve their employees.

1 With that, I'd like to turn things over to Jack.
2 MR. EBELER: Thank you, very much.
3 I'm a longtime admirer of the Commission and its
4 staff and its work and its predecessor organizations, so
5 it's a real honor to be here with my two colleagues.
6 Briefly by way of introduction, I'm with the
7 Alliance of Community Health Plans. Our mission is to
8 promote health care quality and health care improvement, and
9 the mission formally adopts the six aims for quality of care
10 advanced by the Institute of Medicine, through which we
11 shape our work.
12 The members are 14 organizations. You will
13 recognize many, if not most of them. This is about 20
14 percent of your Medicare Advantage market, a statistic that
15 is skewed because Kaiser Foundation Health Plans and the
16 Permanente Federation that Dr. Crosson leads is a part of
17 this. But these are organizations within, in many cases,
18 multi-decade experience in serving Medicare and
19 organizations that will be with Medicare many decades from
20 now, which we're quite proud of.
21 And if you go to the national rankings, these are
22 organizations that typically are among the top performers on

1 the clinical quality indicators.

2 Before we go directly to payment for performance,

3 just to remind the Commission, we're not just talking about

4 payment for performance as an end in itself but instead as

5 one part of a comprehensive effort to transform care, a

6 transformation called for through the excellent work of the

7 Institute of Medicine, which has talked clearly about trying

8 harder will not work, changing systems of care will. And

9 the work of this Commission, which has said quite clearly

10 that we cannot, in Medicare, remain neutral towards quality

11 any longer.

12 Just again, by way of reminder, the Commission has

13 looked at these types of data in previous settings but there

14 are dramatic differences around the country in the quality

15 of care as it's currently measured, as well as differences

16 in costs. There is, at best, a neutral relationship and

17 most likely a negative relationship is indicated in the

18 Baicker Chandra data that I know you've looked at previously

19 between quality of care and health care costs.

20 We are strong supporters of this Commission's call

21 for Medicare to be a quality leader by leading the way in

22 paying for performance, and that health plans can be leading

1 candidates to go there because of the experience and
2 capacity we have over many years in measurement and
3 accountability within the health plan community, an effort
4 that's been led by Peggy O'Kane's organization's terrific
5 work in this area, and because this is a vehicle through
6 which you can leverage the capacity of the delivery system
7 as you go forward.
8 What do we know about health plan performance?
9 Because of the measurement that's in place, we really do
10 know a lot. We've done a lot of analysis of the data that
11 are available on Medicare on the CMS website, as well as
12 commercial data that NCQA has put out for many years. We've
13 shared a lot of us with your staff.
14 We know that there are wide variations in plan
15 performance. We know that there is a high degree of
16 stability in their ranking over time when you look at their
17 clinical effectiveness. And we know that there is, at best,
18 a modest correlation between clinical effectiveness and
19 customer satisfaction as measured by the so-called CAHPS
20 measures, which has caused us to agree with the Commission
21 conclusion in a previous report of yours that the patient
22 and customer already does act and have the capacity to be

1 informed about and act on their own satisfaction indicators.
2 The move towards payment for performance really should lean
3 heavily towards the clinical indicators that are still too
4 discounted in the market.
5 Just by way of example, you can look at these
6 variations in plans at the individual measure level. As we
7 see here, this looks at just five measures. The blue, the
8 dark bars on the left, are the performance at the 25th
9 percentile of plans in Medicare. The gold on the right is
10 performance at the 90th percentile.
11 The more interesting measure here is of the
12 intermediate control measures, HbA1C control and cholesterol
13 control, the second and third bars. You can see dramatic
14 differences in what a beneficiary is likely to get from a
15 plan at the lower 25th percentile and a plan at the 90th
16 percentile is clear. And again, this are just but one set
17 of examples.
18 The other thing that is important to note here in
19 your longer term agenda, and it's something that my members,
20 the leading organizations in this area, which tend to be in
21 that gold area, also stress that there's a lot of white
22 space on the right of that chart, that even really good in

1 health care got what we used to call gentleman C's when I
2 was in college. And I was somewhat of an expert in that
3 phenomenon when I was in college.
4 So I think for this Commission's work, as you
5 advance the transformational agenda, both pulling up the
6 bottom to get better and higher and higher bars at the
7 excellence level is vitally important.
8 You can also look at the data at an aggregate
9 level. This is but one example where you can index all the
10 various effectiveness care indicators to come up with an
11 organizational measure. Again, this is something that we've
12 done using the Medicare data and an aggregation methodology
13 that NCQA uses and updates and continues to change each
14 year.
15 The point of this is not that this is the answer
16 for aggregation but that policy makers have a tool that they
17 can use to aggregate and measure and compare performance.
18 And again we've shared this with your staff, so that they
19 can do the type of more sophisticated analyses and come
20 forward with the type of looks that you really need in this
21 area.
22 The lessons we learned, organizations like mine in

1 which there is a stronger connection between the plan and
2 the provider than typically, we think these are some of the
3 lessons. Again, your staff needs to come forward to you
4 with the more objective analyses. But this stronger
5 connection to delivery does seem to matter in clinical
6 performance. We think that the experience with and
7 commitment to Medicare over a long period of time and
8 accountability to the community does matter. And our
9 members are generally either nonprofit or affiliated with
10 nonprofit systems.
11 But the bottom line message here is the delivery
12 system matters. In some ways, it's obvious but we often
13 forget to state it when we're talking about health plan
14 performance. We have to think of health plans as a vehicle
15 to influence health care delivery.
16 We have four principles that we've advanced in our
17 work with policy makers. Originally Jennifer Dunne, former
18 Congresswoman, and more recently with CMS commission staff
19 and Senators Baucus and Grassley staff in Senate Finance
20 Committee.
21 Payment for performance, we believe, should apply
22 to all of Medicare eventually. It's reasonable to start

1 with health plans because of the tradition that exists
2 there. We believe the measure should strongly favor
3 excellence but that you also have to reward improvement to
4 bring everybody into this and have realistic goals across
5 the board.
6 We believe again, for reasons that the Commission
7 stated so well in an earlier report, you should emphasize
8 clinical effectiveness. And as we start with existing
9 measures, even as we work to develop new and better ones, as
10 I'll talk about.
11 And finally, we believe that it should be financed
12 with a dedicated stream of money.
13 I think it's important, as you look at policy in
14 this area, to look at both the short-term where can you
15 start to get moving down this road as well as longer-term
16 where might one go? Our conclusion in this area was to move
17 forward with some short-term approaches using existing data
18 for health plans. And we were strong supporters of the
19 development of the IOM study that's now underway that you
20 all are involved with on pay for performance. I know Dr.
21 Reischauer and I think a couple of others of you are
22 involved in that effort.

1 In the short-term, you end up really with
2 reporting measurement comparison and payment within some of
3 our existing silos. Physician measurement and payment,
4 health plan measurement and payment and comparisons,
5 hospital measurement comparisons and payments. That's the
6 vehicle, that's what we've got to begin with. And again, we
7 think it important to get going in that area.
8 In the longer-term, we think it important to head
9 towards comparisons across these sectors. The beneficiary
10 out there and the providers aren't necessarily living in
11 those silos. The question is really how can you compare
12 performance across the health care system? Realistically,
13 probably we'll have to have some community reporting in that
14 as you go down the pike. And any system is probably going
15 to end up blending these two approaches.
16 We think that will allow beneficiaries to make
17 comparisons among all sectors, as well as give clear signals
18 and have the greatest transformative effect because it
19 allows providers to make the kind of changes that we know
20 they would really like to do if the system was structured in
21 a way that helped them do that.
22 Obviously, the risk as you go forward that way is

1 it's harder to develop those measures. Again, we don't want
2 to delay where we can start from that, pending that long-
3 term solution. There's also a risk that you end up with the
4 least common denominator approach if you go that cross-
5 cutting way. Again, it's why we think this balanced
6 approach is important.

7 We conclude really with where we start, which is
8 that we support IOM's view that pay for performance is one
9 of the ways to change the environment for care, and would
10 simply endorse your compelling direction in a previous
11 report where you looked at this and concluded that change is
12 urgently needed.

13 We look forward to continuing to work with you in
14 that effort. Thank you very much.

15 DR. NUSSBAUM: Good morning. I am pleased to be
16 with you this morning as MedPAC continues its leadership
17 role in improving quality and performance of the U.S. health
18 care system.

19 I'm Sam Nussbaum, Executive Vice President and
20 Chief Medical Officer of Wellpoint, the nation's largest
21 publicly traded commercial health benefits company, serving
22 more than 28 million medical members. We are an independent

1 BlueCross BlueShield licensee in 13 states and also serve
2 other states through HealthLink and UniCare.
3 I also bring the perspective of 20 years as a
4 basic and clinical researcher at Harvard Medical School and
5 Mass General Hospital and five years at BJC, one of the
6 nation's largest integrated academic and community health
7 systems. And I appreciate the opportunity to speak with you
8 today about quality improvement and pay for performance in
9 Medicare.
10 All stakeholders in our nation's health care
11 system have shared the hopes and disappointments of the past
12 quarter century as providers, payers and policymakers sought
13 multiple ways to improve the quality of care as we manage
14 health care costs. Unfortunately, multiple strategies over
15 the past two decades have not delivered high quality
16 affordable health care.
17 However, the advances in fundamental science and
18 technology, coupled with our imperfect health care system,
19 motivates all of us to evaluate, to test, and to implement
20 evidence based approaches to the practice of medicine
21 including more robust clinically based pay for performance
22 programs.

1 According to a 2004 study by Beth McGlynn and
2 colleagues at RAND, patients receive recommended care just
3 over half the time, increasing the likelihood of poor health
4 outcomes, high health costs, and death. Many of these
5 consequences are avoidable.
6 Even before the RAND study and the landmark
7 reports of the Institute of Medicine, Wellpoint observed
8 wide variation in clinical quality and health outcomes
9 amongst our network hospitals. To better understand these
10 differences in practice patterns and outcomes, we developed
11 a program to help close the gap and improve the quality of
12 care delivered to patients hospitalized in our network
13 hospitals.
14 This inaugural hospital quality program in the
15 Midwest was the precursor to Wellpoint's pay for performance
16 programs today. Most importantly, commissioners, as you
17 prepare to implement pay for performance in Medicare
18 Advantage, I encourage you to consider the fundamental
19 themes of rewarding clinical performance that have proved
20 successful in our quality performance partnerships with
21 physicians and hospitals.
22 Those are to build the trust and collaboration

1 with key stakeholders, to establish meaningful measures that
2 are part of a rigorous process and structure, and to focus
3 on quality health outcomes that improve health.
4 Wellpoint is committed to quality performance
5 improvement through multiple pay for performance programs
6 and these include quality collaborations with primary care
7 physicians, with specialist physicians and with hospitals.
8 Key components of those programs include clinical outcomes,
9 evidence based care and patient satisfaction.
10 Our hospital quality programs are guided by core
11 principles including a comprehensive set of metrics that
12 address not only quality of care in clinical outcomes and
13 patient safety, but processes of care and organizational
14 management structure. Measures are based on both best
15 hospital practices but increasingly, as national guidelines
16 such as those of NQF are developed, we have adopted and
17 consented in those guidelines. These guidelines and
18 approaches are also developed through an interactive process
19 with our hospitals, reporting as for all hospital patients.
20 And we strive to minimize -- and I know how important this
21 is to you -- the administrative burden for hospitals and
22 doctors.

1 Most important, financial incentives for clinical
2 performance, quality care delivery and error reduction are
3 components of our renewing hospital contracts.
4 As one example, Wellpoint's Coronary Services
5 Program includes an extensive set of quality outcomes
6 measures for acute myocardial infarction and for procedures
7 such as coronary artery bypass grafts and coronary
8 angioplasty. Our measures are consistent and endorsed by
9 the American College of Cardiology and the National Quality
10 Forum.
11 As you can see in this slide, which is not in your
12 packet, risk-adjusted results are analyzed and reported to
13 hospitals, to cardiologists and cardiothoracic surgeons.
14 And also as you can see, mortality rates vary from under 1
15 percent to 6 percent. Of interest, we found no relationship
16 between volume of procedures and outcomes.
17 NQF measures are also prominently reflected in our
18 Quality Insights Hospital Incentive Program, we call that
19 QIHIP. And you can see that those measures in red are those
20 that reflect an NQF measure. Through QIHIP, hospitals earn
21 payment incentives based on their performance in three
22 important areas: patient safety, patient health outcomes,

1 and 15 percent patient satisfaction. The performance
2 objectives used by the program are based on care processes
3 promulgated by the Joint Commission, the Leapfrog Group, and
4 professional organizations such as the American College of
5 Cardiology. As mentioned, they include NQF and the Agency
6 for Health Care Research and Quality. Hospitals and QIHIP
7 and other programs earn payouts and incentives beyond their
8 contractual reimbursement if they achieve or exceed quality
9 improvement scores.
10 These programs are tailored to specific contracts
11 and they range from 1 to 5 percent of total hospital
12 payments. Those hospitals that have best performance across
13 multiple measures, and here's an example of one measure.
14 You can see these are Virginia hospitals and pneumococcal
15 vaccination rates. But those hospitals that have best
16 performance across multiple measures receive the greatest
17 reimbursement. Those with lowest performance are improving.
18 Our experience in pay for performance has shown
19 that rewarding high scores creates a tangible incentive for
20 quality improvement. Over the past three years we have
21 increased the proportion of payment to hospitals that are
22 based on clinical quality.

1 Wellpoint has many physician pay for performance
2 programs. One of our health plans, BlueCross of California,
3 launched a quality incentive program for HMO physician
4 groups in the mid-1990s. BlueCross of California, BCC,
5 introduced a quality program with HMO physicians because
6 this product more closely linked patients with their primary
7 principle physicians. Consequently, it was easier to
8 connect improved patient outcomes to specific physicians and
9 reward quality improvement.
10 In 2001, this scorecard was expanded to include
11 more quality measures and to increase the reward for high
12 performing physicians. Today the average bonus payment is
13 approximately 5 percent of the total health plan capitation
14 or other reimbursement to physician group. Our surveys
15 indicate this is a level more likely to affect behavioral
16 change in physician practice.
17 Other Wellpoint physician incentive programs
18 tailored to specialty physicians and to medical groups have
19 increased reimbursement by 5 to 10 percent or higher of our
20 total payment. Additionally, BlueCross of California is a
21 member of the Integrated Health Care Association in
22 California, a coalition of health insurers, providers,

1 hospitals, physicians that use similar measures to reward
2 physician groups for improved quality performance. The
3 health plans and providers agree on a common set of metrics
4 to assess clinical outcomes and those outcomes also include
5 investments in new technology. Effective generic drug
6 prescribing is also included.
7 As seen in this scorecard overview, physicians can
8 assess their performance against peer performance.
9 In 2002 BlueCross of California piloted a quality
10 incentive program for its PPO product and physicians.
11 Developing a quality incentive program linked to a PPO was
12 more challenging than an HMO pay for performance program.
13 As the Commission continues to evaluate pay for
14 performance in Medicare Advantage, it is important to
15 recognize these differences between product types.
16 BlueCross of California selected measures that could be
17 collected solely from claims data for this PPO product, as
18 chart reviews of individual physicians for each patient
19 encounter would have added significant administrative burden
20 and cost.
21 To achieve our goals, the health plan chose 16
22 standards very similar to HEDIS measures and including HEDIS

1 measures. In fact, in the appendix I have listed those
2 HEDIS measures outlined by the Medicare Advantage PPO HEDIS
3 measurement feasibility assessment report and also a set of
4 quality measures proposed earlier this year by the
5 Ambulatory Care Quality Alliance.
6 Establishing clinical performance measures that
7 can be reported consistently by all health plans will
8 continue to pose a challenge until the U.S. health care
9 system employs the widespread use of electronic medical
10 records. I have outlined those challenges and potential
11 solutions on this slide.
12 We must assure that quality measures are
13 appropriate for all types of health plans. Additionally,
14 the Commission should embrace an approach that allows CMS to
15 compare and reward plans by type and to establish separate
16 quality incentive pools by plan type.
17 Moreover, for Medicare beneficiaries in
18 particular, we must establish more robust measures for
19 specialty care including for example orthopedic care, and
20 for outcomes and optimal management of common chronic
21 illness.
22 There are valuable lessons from our years of

1 experience in rewarding clinical performance that may be
2 applicable to pay for performance in Medicare Advantage.
3 These lessons, listed here, include that health plans,
4 physicians and hospitals each play a pivotal role in quality
5 improvement and should be measured for quality performance.
6 Measuring quality improvement does guide performance
7 improvement and allows comparison across hospitals, medical
8 groups, physicians, and health plans. These programs can
9 serve as a powerful incentive for performance improvement.
10 The measures should be robust, especially for
11 specialty care. They should reflect the national standards
12 and be meaningful for consumers. The incentives must be
13 appropriately structured to affect behavior change. And the
14 effective programs must be based on collaboration and have
15 sufficient flexibility to evolve over time.
16 We have found that medical specialty societies,
17 such as the American College of Cardiology or the American
18 College of Radiology and others, can be called on to promote
19 professional standards and ensure greater consistency in
20 health outcomes.
21 In conclusion, I want to summarize several
22 principles that should help guide the final regulations for

1 pay for performance in Medicare Advantage. These are
2 performance measures should be based on data that can be
3 collected and reported in a consistent manner across the
4 continuum of health plans.
5 Comprehensive quality performance measures should
6 emphasize clinical process and outcomes but also include
7 patient satisfaction.
8 Performance measures should target results that
9 health plans can influence.
10 These measures should focus on high cost chronic
11 illness, support evidence-based medicine and be meaningful
12 and consistent for all Medicare beneficiaries.
13 These incentive program should be designed to
14 raise the performance of all. We must avoid financial
15 incentives that could potentially force health plans to
16 reduce comprehensive benefits based on financial neutrality
17 approach that funds quality incentives by reducing Medicare
18 Advantage payment benchmarks to health plans.
19 And most important, these measures must be part of
20 a much more comprehensive program that includes integrated
21 patient management solutions, care and disease management,
22 medication and pharmacy programs aligned with medical care,

1 as well as behavioral health services.

2 Thank you.

3 MS. O'KANE: It's a real pleasure to be here. I

4 know many of you.

5 We've been reading with great enthusiasm the

6 reports that you've been putting out, which we see reflect a

7 great alignment between our point of view about how to get

8 to better health care quality and value and yours.

9 I think you know who NCQA is, so I'm going to skip

10 over some of these. This is basically an outline of my

11 presentation.

12 What can we expect for quality? How should we

13 think about the accountable health plan and at the same time

14 think about evolving an accountability agenda down to the

15 provider level? How do we drive a value agenda? And what

16 is the role of pay for performance?

17 We are a nonprofit. We spun off from the HMO

18 industry in 1990. We are very proud that we are an

19 independent organization and a number of your commissions

20 are board members, like Senator Durenberger and Ralph

21 Muller. We are very proud of our independent governance.

22 The way we've moved the quality agenda is really

1 to unite the payers, the consumers, the quality experts, the
2 consultants, the providers, and health plans, and try to
3 come up with common definitions of quality and then move
4 them forward.
5 We've been involved in a lot of pay for
6 performance demonstrations at the provider level, notably
7 IHA -- which Sam just mentioned -- in California, which is a
8 broad collaborative with the participation of seven health
9 plans and over 200 medical groups.
10 The Community Measurement Collaborative in
11 Minnesota, which again benefits from the fact that
12 physicians in Minnesota tend to be organized in large units.
13 I think I'm going to show my bias here that I think we're
14 only going to get to maximum performance in groups that are
15 big enough to really have robust measurement and to have
16 robust incentive to be efficient. And I think that means
17 payment reform, as well.
18 We're also very much involved as the underpinning
19 of the Bridges to Excellence program, which is a group of
20 different self-insured employers in various markets really
21 spearheaded by GE. These tend to focus more at the smaller
22 group level.

1 We're very proud to say that many of the health
2 plans, as well as the employers now, are moving pay for
3 performance through our recognition programs. So there are
4 a variety of ways of incenting physicians to get these kinds
5 of recognition from showing seals in the directory to
6 helping practices collect their data, paying rewards or
7 paying application fees, to active steerage into elite
8 networks that may have our recognition programs as one of
9 the criteria.
10 Let me just dwell for a minute on this slide.
11 This was developed by Nico Pronk at Health Partners and it's
12 in a book that was written by George Halvorson and George
13 Isham. And really it reflects what we want from the health
14 care system.
15 If you think about the Medicare population, since
16 that's what we're talking about, at any given point people
17 are really pretty healthy and low risk. And then, for a
18 variety of reasons, age, risky behavior, whatever, they move
19 to the right and they get sicker. What we really want from
20 health care is exerting pressure to keep people towards the
21 healthy end of the spectrum, both from wellness and
22 prevention programs at the far left through disease

1 management when people are sick and have symptoms, really to
2 keep them I think out of the hospital as much as we can and
3 active and healthy.
4 I think that's one of the ways in which health
5 plans add value.
6 One of the other ways that they add value directly
7 is by coordinating care for those 20 percent of patients at
8 the very sick end who are generating 80 percent of the
9 costs. As we know from reading about what's going on with
10 these patients, a lot of those costs are really not
11 legitimate costs of treating the illness. They're costs of
12 poor coordination, redundant care, medical errors and
13 actually human suffering that costs a lot of money. So
14 plans can directly add value at that end of the spectrum, as
15 well.
16 Most HEDIS measures really have focused on these
17 prevention and disease management functions of the plan and
18 I think -- I was just at a meeting where Jack Rowe said we
19 have three categories of measures, or three boxes for
20 measures: in, out and too hard. That turns out to be very
21 hard, but it think it's very, very important for us to
22 figure out ways to capture where there is good coordination

1 and to make comparisons between entities that are claiming
2 to do this and what's going on in uninterrupted Medicare.
3 So we know quality can be measured. We need
4 accountability, I think, at all levels of the system. If
5 plans are in the value stream then I think we need to
6 demonstrate how they add value to the Medicare program. As
7 I said, they can do that directly. They can do it by pay
8 for performance initiatives like the kinds of things that
9 Sam is talking about. But we need to be able to capture
10 that value add and that reward it.
11 So the accountable health plan model, it has
12 worked. Ironically, it's a shrinking universe on the
13 commercial side, as many employers have lost hope in the
14 ability to control costs and I think have really kind of
15 moved themselves over to what I think is leading towards a
16 voucher model. But for the plans that are accountable, the
17 focus on measurement reporting and transparency has raised
18 performance over time.
19 Interestingly, if you look at the results over
20 time in Medicare, we've been looking at the commercial
21 compared to Medicare -- and I didn't bring that slide today.
22 But the rate of improvement in the commercial populations is

1 actually steeper. I'm not really clear what that's about
2 but just something to note.
3 This is another measure that we've had very good -
4 - these are all Medicare data -- good results over time. As
5 you know, this is one of those real investments. When you
6 control high blood pressure, you really reduce the risk of
7 heart attacks, heart failure, kidney failure, strokes, et
8 cetera. So really pretty good results.
9 Another one that we find kind of puzzling is
10 breast cancer screening is declining. It may be because
11 women are reading in the newspapers about some questions
12 about what's the real bang for the buck here, even from the
13 patient's point of view.
14 Patient satisfaction. I note that both on the
15 plan side and in classic Medicare there's a decline in
16 patient satisfaction. I speculate that this is due to a lot
17 of confusion around what Medicare options there are. I
18 don't know if you've looked at this and if you have a point
19 of view about it but it is certainly something to be noted.
20 This is the top 10 Medicare plans last year. This
21 is HEDIS only. And while we're on that topic, I guess I
22 think that rewards shouldn't be only for clinical

1 performance, that we do have a task of convincing Medicare
2 beneficiaries that they can get superior care when they join
3 health plans. And if they don't feel that they're treated
4 appropriately, I think then the clinical performance may
5 never really penetrate their consciousness.
6 What should we do? Like Jack, I think we need a
7 consistent value agenda that really looks across plan types
8 and across segments. On the issue of should PPOs be
9 accountable for the same things as HMOs, I would argue that
10 we could just be neutral on that and say the broader your
11 set of accountabilities, the more could be at stake for pay
12 for performance. And then your actual performance would
13 also drive what you get.
14 So if you choose to have a narrow set of things
15 that you're accountable for, you have less upside. That
16 seems like a way around much of the arguing that's gone on
17 over the past 10 years to me.
18 We need to reward performance improvement and
19 accountability. The P4P incentives clearly have to outweigh
20 the bad incentives of the system. We know that we have
21 plenty of bad incentives built into to the system. If the
22 P4P incentives pale in comparison to the bad incentives,

1 then I don't think P4P will work.

2 We need to quantify the value add of plans and
3 providers and then pass the rewards down the value chain
4 according to what is generated in terms of value.

5 I think P4P, as we currently see it, is a start.
6 I personally believe that we aren't going to get the
7 benefits of really much better efficiency until we go to
8 some kind of accountable bundled payment. As I said, I
9 think it will not occur in individual practices, although I
10 think there is the capability now of joining physicians
11 together into accountable networks that could be rewarded on
12 some larger basis.

13 I think there needs to be financial neutrality.
14 Payments should be neutral among plan types but rewards
15 should be according to the value add. I think I've made
16 that point.

17 I think we need baselines. We need a national
18 baseline and we need community baselines. And then the
19 value add should be calculated both at the community level.
20 And I think nationally the disparities we have across
21 geographic areas, I think, are a huge issue that this
22 program needs to address.

1 Let me just draw your attention to this slide for
2 a minute because I think it's a way of thinking about all
3 the different strategies that we have right now for
4 improving value. This is something that we just developed
5 with a consultant who's been working with us. And it
6 really, I think, translates well to what Medicare is doing.
7 If you think about, on the Y axis, you think about
8 plans at the top and providers at the bottom. If you think
9 about employers taking responsibility on the right and
10 employees taking responsibility on the left, it gives you
11 kind of four quadrants. We see these quadrants in play
12 right now in what's going on in the employer community.
13 If you look at the upper right quadrant, you have
14 the accountable plan strategy, which I think is still strong
15 with a shrinking segment of Fortune 500 companies, typically
16 heavily unionized companies.
17 On the left you have again more plan
18 responsibility but a defined contribution model, really kind
19 of FEHB-like, if you think about it, moving towards more
20 emphasis at the provider level.
21 On the left you have the sort of PPO, not really
22 interventionist PPO, with transparency to the provider

1 level.

2 And then if you go to the right bottom quadrant,

3 it's the employer that says well, I'm not sure I can trust

4 that really. So they are really looking for high

5 performance networks, P4P, more incentives to drive besides

6 just a kind of market put it out there and let's see what

7 happens.

8 If you take that kind of logic, I think you have

9 the same kind of thinking going on with the Medicare

10 program. So you have MA plans up in the right upper

11 quadrant. You have group practice and Section 646 demos in

12 the right lower quadrant. You have DOQ, DOQIT.

13 I think it really behooves us to think about the

14 comparative value add. And I don't think there's a single

15 model for every geographic area in the country. It's

16 obvious that you can't roll out an IHA-like demonstration in

17 New York City. You have organization of physicians in

18 California and some other markets that enables that to

19 happen.

20 But I do think that we have to have much better

21 ability to benchmark what the value add is both locally and

22 nationally in order to have a coherent and strong value

1 agenda going forward.

2 Thank you

3 MR. HACKBARTH: Thank you. Those were great

4 presentations. And thank you all for all of the work that

5 you do. You've all been great leaders in trying to improve

6 quality.

7 Let me see a show of hands of people with

8 questions. We'll go around the table. Why don't you start,

9 Ray, and we'll go right around.

10 DR. STOWERS: Sam, you made an interesting comment

11 in the middle of your hospital part there about you did not

12 find any correlation between volume and quality? That was

13 my first question. Did you want to comment on it? Because

14 we talk a lot about centers of excellence and all of that.

15 DR. NUSSBAUM: I'd be pleased you. As you know,

16 many of the elements of the initial Leapfrog measures

17 suggested that evidence-based referral was the more

18 procedures that you did the better the outcomes. Oh course,

19 there's tremendous amount of literature to support that.

20 But I believe that our data, and we've looked about both

21 joint infections after orthopedic surgery, we've looked at

22 the data that you saw on mortality rates, didn't show that

1 correlation.

2 And I believe what happened is that over the last
3 five years or more that very skilled physicians are
4 practicing in community settings and getting superb results.
5 I know that I've talked to others about the data and they
6 also, many colleagues are not finding that the earlier
7 information is holding up.

8 And that's why we think that volume is a surrogate
9 but nothing is better that measuring the true outcome of
10 care. One of the elements that I've emphasized in our
11 hospital quality programs that at their most robust level
12 are about 80 elements, these are clinical elements. They're
13 not elements that can be achieved through administrative
14 claims data.

15 We are working with the Society of Thoracic
16 Surgeons, the ACC, and others to create better databases.
17 But the goal is to actually do deep clinical exploration.
18 And I think the reason for that is just in the data that I
19 shared.

20 DR. STOWERS: Thanks, I thought that was real
21 interesting.

22 Peggy, you mentioned that the large groups was

1 kind of the way to go, and the Commission has talked about
2 that, too. But I think in the spring we were kind of
3 struggling with what to do with the rural and the small
4 group practices. Has there been any thought into how that
5 might be organized? Or is that through plans only?
6 MS. O'KANE: First of all, I don't think everybody
7 needs to be in one mode of practice. I think if we solve
8 for 80 percent of the country, we can probably afford to
9 live with a little bit slower roll out at the rural level.
10 But I do think the Internet -- I mean, the idea of
11 having some way of stitching together physicians, getting
12 them to benchmark -- actually there is actually a lot of
13 really good work going on with a lot of specialty societies.
14 The boards are changing the way they're looking at
15 performance for physicians. There are ways of having
16 physicians participate in registries and so on, and really
17 continuously improve their performance.
18 So I think it's possible but I don't think we're
19 going to get to everybody being in medical groups in our
20 lifetime.
21 MR. SMITH: Thank you all. This was terrific.
22 Jack, let me use you or a difference between your

1 slide and what you said as a way to ask a question that's
2 been on our minds in thinking about the design of P4P.
3 Your slide said pay for performance should be
4 financed with a new dedicated stream of revenue. You left
5 new out when you spoke, and I was struck by that. One of
6 the design questions for us, of course, is whether or not
7 there needs to be a downside associated with a P4P plan.
8 Sam, you explicitly said there shouldn't be. Jack, I wasn't
9 quite sure what you said.
10 But forgetting the specifics of the presentation
11 today, can you imagine a P4P design that holds the baseline
12 constant and doesn't redistribute, that's robust enough to
13 meet the test that Peggy raised at the end of her
14 presentation?
15 MR. EBELER: Give me the design again.
16 MR. SMITH: A simple version of a design question
17 is should the upside be financed out of reductions to folks
18 who either failed to improve or failed to hit a threshold?
19 Or should it be financed, as your slide said, with the new
20 stream of revenue that would mean there was only an upside
21 and the downside presumably stayed in the current mode?
22 MR. EBELER: Absolutely. We have a position on

1 this that is to get people invested in it it would be best
2 to have new money. But there's obviously a difficult budget
3 problem that the Commission has to respect. There are
4 examples of pay for performance in the private sector that
5 do it either way. And we certainly understand that that's
6 an option as you go down the pike.
7 MR. SMITH: Let me try to ask you, this isn't a
8 primarily I think a budget question. It's a robustness
9 question. And I guess the design issue is if there is no
10 price for failure to improve or failure to hit a standard of
11 excellence, does the incentive that you hope to get on the
12 upside work without a downside? Set aside the budget
13 issues. Assume we're only concerned with efficiency.
14 MR. EBELER: Two things. One is what we view as
15 up and downside the day after it's implemented is perceived
16 differently out there. Whether you have an increment of 2
17 percent or a withhold of 2 percent, those who aren't going
18 to get it will perceive themselves as losing. So I think
19 the behavioral effect can be the same. It does end up as a
20 financing issue.
21 And again, there are examples of both out there
22 that folks have used.

1 MS. O'KANE: Again, if we were able to benchmark
2 against what's going on in the community in a robust way I
3 think that would give us the answer. If a plan is
4 performing better than the average in the community, that
5 gives you something to shoot for.
6 I personally think it's hard to take money away,
7 especially from Medicare. But holding back the rates of
8 increase, I think that's been suggested by this body, I
9 think that's perfectly legitimate. I think it's very, very
10 important though, to have the numbers to point to about what
11 the logic is for increasing payments to some and not to
12 others, or more to some than to others.
13 DR. NUSSBAUM: This is the same critical question
14 that we asked ourselves because as we sort of budgeted and
15 many of our members are in self-funded accounts. What we
16 did is take a careful look at many of these programs and
17 have found that overall we could reserve a pool, 5 percent
18 in some cases, and even 10 percent for certain specialty
19 physicians. And that pool literally funded the incentives
20 and funded improved clinical performance.
21 Let me give an example in women's health. We set
22 up a set of measures that were not only preventive women's

1 health services by appropriateness of hysterectomy. So
2 we're following the ACOG guidelines. In addition, we wanted
3 a wise prescribing of generic therapies when they were
4 equivalent.
5 What we found is that there were more than
6 sufficient savings to not only pay the increase of 5 to 10
7 percent to physicians, but actually there was additional
8 money that went back to the plan and went back to our
9 employers.
10 As we look at our hospital programs, we're finding
11 very much the same issue. I know many of you know this,
12 you've studied it, you've contributed to this important
13 advancements in understanding this field. But as you reduce
14 hospital infection, as you enhance immunization rates, the
15 savings that we've seen are great.
16 And when we get evidence-based care in our disease
17 management programs, and it's a very different discussion,
18 we actually have seen savings range from two-to-one to four-
19 to-one of the investment. That's how we're funding it.
20 We're concerned that if this is viewed as a
21 takeaway, the have-not -- particularly at the physician
22 level, I think hospitals have resources to do it

1 differently. But at the physician level, those that get
2 less will invest less in electronic health records, in
3 infrastructure in their offices. And I think we will create
4 even greater disparity between the high-quality performers
5 and those that are poor performers. And I know how
6 concerned we all are for access to care in urban areas and
7 rural areas and I think we need to look very seriously at
8 that issue.

9 MR. HACKBARTH: Sam, could I just pick up on that
10 point for a second? I've often heard that point made, that
11 the physician will respond to losing money by investing
12 less. I'm not sure I understand the logic of it, because
13 that means that they're going to doom themselves to
14 successive cycles of worsening performance relative to the
15 leaders. Now I can understand that some people may feel
16 financially strapped.

17 An alternative is to say well, I need to affiliate
18 with a group. I can't afford to practice by myself or in
19 this small group. At least in geographic areas, Ray, where
20 there are alternatives, it's a strong motivation to move
21 where Peggy suggests we need to go, and I also believe we
22 need to go, at least in the big areas.

1 DR. NUSSBAUM: Certainly you're describing the
2 preferred outcome, but the reality today for Medicare
3 beneficiaries and for all of us is that physicians are
4 largely practicing in small constellations. I think that's
5 the reality that we need to balance with your very important
6 concept that the more that physicians can organize and build
7 infrastructure, invest, the better of the whole health care
8 system would be.
9 My other concern is that, and it relates to the
10 dollars involved. As many of us who have been in the
11 hospital world know that 1 or 2 or 3 percent matters
12 significantly when you're dealing with billion-dollar
13 revenues and budgets. But for physicians, 1 or 2 percent
14 for those practices to the doctor will say I can't afford
15 the electronic health record system, medical record system
16 for $50,000. So for them, a few thousand dollars or a few
17 hundred dollars would not drive the right behaviors, I fear.
18 DR. KANE: I wanted to follow up on something that
19 Jack mentioned in one of his slides and I just wanted to
20 see. I find it very interesting that you had a slide
21 showing that there should be comparisons and incentives
22 across financing and delivery models. At the bottom of the

1 slide you put community reporting and payment. I'm
2 wondering what did you envision there? What kind of
3 communities? What kind of reporting? What kind of
4 accountability? What kind of payment did you envision that
5 would be across the financing and delivery models? Because
6 I think that's a very interesting concept.
7 MR. EBELER: I think as you go forward here, again
8 in a long-term, you really do need to get to some sense of
9 measurement at the delivery level, not just through the
10 plans. I think Senator Durenberger could tell us about
11 what's going on in Minnesota, where they are actually
12 measuring through a special project that the NCQA has
13 underway and I think Peggy mentioned, performance at the
14 network and ultimately the group level on the various HEDIS
15 indicators across all the health plans, and in effect
16 attributing the data to the plans after measuring it at the
17 delivery level.
18 So you can go to a website there and see what
19 particular networks and clinics are doing on a variety of
20 HEDIS and CAHPS indicators.
21 If you head towards a world of measurement where
22 the beneficiary and the delivery system starts comparing

1 themselves that way, some of that reporting may end up
2 coming to you through a community-based enterprise, which is
3 what they do in Minnesota, rather than just coming at you
4 through the payment mechanism. It is one model that is
5 interesting as you go forward.
6 And I think it does help get to a little bit of
7 the discussion you're having here about how do you get the
8 delivery organization heading into a little more sort of
9 even virtual networks, even if it's not a tightly organized
10 multispecialty group practice, which may be the best
11 performer. So it's an interesting example as you head down
12 that road. That's really what I had in mind.
13 DR. KANE: In that concept, is there some type of
14 new organization then that perhaps produces the reports and
15 unifies the information?
16 MR. EBELER: Yes, there is.
17 MS. O'KANE: There are organizations that are
18 working on this strategy right now. There are disease
19 management firms, for example, that are really trying to
20 position themselves to be helpers to the physicians.
21 MR. EBELER: The other thing I'd point out here is
22 that we talk a little bit about rural care. Is not

1 necessarily the laggard we always imply. You look at what's
2 going on in places like Geisinger, Security Health Plan,
3 Marshfield Clinic in Wisconsin, where part of the
4 imperatives have created some of what the chairman is
5 talking about, where folks are trying to connect a little
6 bit better and are performing at levels that are quite
7 spectacular.
8 DR. KANE: Thank you.
9 MR. DURENBERGER: And add to that the Deaconess
10 Billings virtually integrated system in Eastern Montana.
11 This is a great line of questioning. I'm going to continue
12 it and I just want to begin by saying the three of you are
13 just the greatest people in this profession and you ought to
14 be on everybody's what they used to call Rolodex list, now
15 it's the contact list, and so forth. So I thank you for
16 what you do and coming here.
17 David had the question about should we be paying
18 less to the poor performers? The fact of the matter is we
19 do right now, in the Medicare program, on purpose in effect
20 is paying the high performers less and the low performers
21 more. I don't know how you get that to be an issue that
22 people can understand within the practice of medicine. I

1 don't mean the public in general.

2 But unless it's understood in the practice of
3 medicine that the reverse exists today, Jack has it in the
4 Baicker Chandra Health Affairs where you can see where all
5 the high performers, whether it's on a cost-effectiveness or
6 whatever it is basis, they're all there.

7 With that in mind, and Jack's comments in response
8 to Nancy's question about community reporting, and Peggy
9 talked about community baselines and so forth, when I'm in a
10 group of people critical of MMA, and everybody finds
11 something wrong with everything. But I say don't you think
12 the pony in the manure pile, so to speak, is
13 regionalization? We've started this process of thinking
14 regionally, CMS has always been sort of regional and now
15 they're going regional with their carriers and
16 intermediaries, and they're going regional with PDP, PPO.
17 And then someplace out there, could there not be a Medicare
18 program that responds to communities, the national
19 communities that exist in this country?

20 I think we know from this data and from Nick's
21 experience and some other people in this room that there are
22 natural communities in Hawaii and the Pacific Northwest and

1 the Upper Midwest and in new England, just to take this
2 current data, and that something is going on out there way
3 beyond health plans and way beyond classic Medicare or
4 whatever it is that is of value that needs to get tapped
5 into.

6 So my question of you is as you look at the
7 current Medicare financing system is there one important
8 change that you would advocate in that system that would
9 move us in the direction -- or does it exist already and I
10 don't know about it -- that would move us in the direction
11 of regionalizing or community-izing the financial rewards or
12 incentives for performance in which performance is not
13 something we necessarily dictate from up here? We can help
14 the process, as plans do and others do. But performance at
15 least is, in part, a reflection of what these natural
16 communities of physicians and hospitals and health plans and
17 everybody else have evolved and told us are ideal outcomes,
18 evidence-based medicine, et cetera, et cetera.

19 MR. HACKBARTH: Dave, can I just add to that
20 question? I'd also be interested, along those lines,
21 whether in these high performing communities you see
22 significant variability among the providers within the

1 communities as part of that?

2 MR. DURENBERGER: Thank you.

3 MS. O'KANE: The answer to that question is yes,

4 significant variability. Now I think I'm out here on this

5 limb, trying to answer your question, Dave.

6 To me again, if we had good benchmark information

7 at the community level and we really rewarded the highest

8 performers, and we started telling communities -- this may

9 be completely crazy -- but telling Miami okay, the party is

10 over and we're going to now start holding you accountable.

11 We're going to have targets for you for improving your

12 performance, for bringing your costs down, or something like

13 that that just at least begins the process.

14 Reading Victor Fuchs' piece in the New England

15 Journal, I don't know how many of you read it, saying our

16 social insurance system is kind of on the rocks. And I can

17 see a time in 10 years, he's saying, when we may have to go

18 to a government program with vouchers. Just think about the

19 scenario of handing somebody a voucher in Minnesota that's

20 worth a fraction of what somebody gets in Miami.

21 And I don't think that's an unrealistic scenario.

22 The ability to really control the costs globally seems

1 really pretty far away.

2 So I think that starting to really send a signal

3 to communities that what happens in your community with the

4 health dollar matters and we're not a neutral payer and

5 we're not going to keep throwing good money after bad. I

6 don't know if that's at the level of detail that you were

7 looking for.

8 DR. NUSSBAUM: Senator, I think it's an intriguing

9 concept of these natural communities because we also see,

10 rather independent of all of our programs or those of our

11 colleague health plans or Peggy's great programs, is that

12 delivery systems evolve. And the quality of care, for

13 example Peggy, in New England is on HEDIS measures, most

14 measures, far surpasses that of other parts of the country,

15 of Minnesota, as you know.

16 But to me there are two considerations. And that

17 is that some of these natural communities, and I've seen

18 some in the Midwest, also have very high use rates of

19 inappropriate services. Some of it is based on the training

20 that took place or the concepts and collegiality that may

21 grow up within specialty areas. And some of these natural

22 communities have a very entrepreneurial flavor today. New

1 imaging centers drive use of advanced imaging procedures
2 that are not leading to better health outcomes or have not
3 been of proven benefit.
4 So I think the natural community content, as
5 powerful as it is, can go both ways.
6 One way I think, though, that we can bridge this
7 is there are those foundational issues, and it's to really
8 involve specialty medical societies in a very different way
9 than they've been involved to date. Because there are the
10 standards of care that we want. We have, based on Jack
11 Wennberg's work and others, this tenfold variation in very
12 common procedures. We find it in the commercial plans, too,
13 as you all find it in Medicare. So I think that might be
14 one way of reducing the variation.
15 And Arnie know so well that even within very well
16 established clinical units and medical groups, I think that
17 you also see continued variation amongst providers that's
18 reduced. But if you want to do analyses on these high
19 performing networks, you don't even, within the same
20 community, the same practice group, see the consistency that
21 we would want to achieve.
22 MR. EBELER: I would just add a couple things,

1 Senator, to the question. In many ways it gets to why we
2 ended up at pay for performance as a policy instrument.
3 It's not in that peer reviewed literature but the Gil Gaul
4 series in the Washington Post that really laid out
5 contrasting utilization and spending patterns, looked at
6 Minnesota versus Miami. You can get into the types of
7 policy discussions this commission as watched and
8 participated in about moving money from my region to your
9 region or urban to rural and all those fun difficulties that
10 always fall on their face.
11 We concluded the best way to do that would be to
12 have very clear transparent measurement in those two
13 communities and move money around based on their quality
14 performance. We're confident a place like Health Partners
15 in Minnesota will do quite well under that.
16 As you know, underneath that, as the community
17 measurement shows there, the delivery does differ in its
18 performance. But we think the transparency at the plan
19 level, and then ultimately translating through to the
20 delivery level, will help. The payment for performance will
21 help push that as well.
22 I think what we don't do in that model is get to

1 what is the other half of the Baicker Chandra article, which
2 is a good portion of that variation. I think they said 43
3 percent, when you adjust for everything you can adjust for,
4 is probably supply induced demand. How exactly we get to
5 that issue for discretionary services is sort a little bit
6 outside the scope of what we're talking about because it
7 really does jump right at you in the fee-for-service
8 sectors. I don't think you give you an answer to that part
9 of your question, sir.
10 DR. MILSTEIN: I had one question for Sam and one
11 for Peggy.
12 Sam, you've been around long enough to remember
13 that the initial attempts to measure quality in the Medicare
14 program began with entities like PSROs, that more than 30
15 years ago were beginning to do what NCQA has done much more
16 systematically for us recently, which is measure the rage of
17 compliance with evidence-based guidelines by doctors.
18 The numbers that came to us in 1975 were not much
19 different than the numbers we're getting in 2005, Peggy's
20 plans aside, about 55 or 60 percent rate of compliance. So
21 we've had 30 years of evidence of major failures in quality
22 and not tremendous progress over those 30 years.

1 As a physician, you're also aware of this concept
2 of when you're trying to inject a therapy you don't want to
3 either underdose or overdose a patient. You want it just
4 right.
5 I think nobody that this Commission has heard from
6 has more experience than you in interacting with both
7 organized physician groups and solo physicians in your
8 various positions over the last few years. If you could
9 write down on a piece of paper your prescription for
10 Medicare P4P in terms of magnitude of dose expressed as
11 percentage of total compensation that ought to be hinged on
12 quality of care, and your goal was to move America, through
13 Medicare program leadership, across the quality chasm in 10
14 years rather than 110 years, what would be on your
15 prescription pad as a percentage of total compensation into
16 P4P, A for hospitals and B for doctors?
17 DR. NUSSBAUM: I will give you very specific
18 answers. For hospitals, as low as 1 to 2 percent drives
19 improvement. Because when you're looking at that $500
20 million or, Ralph as you know, very large budgets, this is
21 the difference between profitability and investment in
22 infrastructure. So that's what we have found. I think it

1 can and should be higher, but I think I would say 2 percent
2 is a good baseline.
3 Physicians, unfortunately, require a greater
4 percentage of payment. And this varies by specialty group.
5 I think we've all seen the need for greater investment in
6 our primary care physician groups. We just look at medical
7 school and we look at the group of physicians that are
8 selecting primary care specialties and we need to make an
9 improvement. So I would suggest that that's a 10 percent
10 number.
11 I think for specialty care it's smaller, we found
12 5 percent.
13 So those are the very discrete numbers I would
14 give. I think there can be absolute ranges around them.
15 But to envision that 1 or 2 percent will move the needle for
16 physicians won't happen.
17 And like you, Arnie, again this is three decades
18 of a field of dreams that has been shattered for all of us.
19 So whether we look at every exciting innovative program that
20 we've applied, why haven't we moved the needle more?
21 This I think, and conjunction with some pretty
22 intriguing ideas, I know Peggy used the term vouchers which

1 I worry very much about. But some of the elements of some
2 of the new consumer-directed products that we and others are
3 developing, do things like this. They give consumers
4 dollars, whether it's in a spending account or through
5 premium. They give them actually dollars for enrolling in
6 care management programs. They actually pay significantly
7 more when you have a health coach, for filling out health
8 risk assessments so you can make wise decisions.
9 And I think that is going to have to be a piece of
10 this, too. The consumer engagement, the Medicare
11 beneficiary engagement. And that, of course, is a very
12 complex journey.
13 DR. MILSTEIN: Peggy, my question for you is the
14 vast majority of decisions that we make here, we wish that
15 we had a quality-ometer that we could apply to know whether
16 there was a change in the quality-ometer before or after a
17 particular policy, whether there likely would be one.
18 NCQA has really led the nation in, I'll call it
19 sort of two facets of a quality of care rating. One is
20 measures of adherence to processes of care. And secondly,
21 measures of patient centeredness.
22 I think less well-known is the pioneering work

1 that NCQA has done on measuring outcomes within Medicare
2 populations over, for example, 24-month periods of time. I
3 know that that's a nontrivial measurement task to
4 accomplish. But I know that those measurements have been
5 applied to Medicare Advantage plans year after year, that is
6 measuring risk adjusted change and the ability of patients
7 to function in life for Medicare enrollees in Medicare
8 Advantage plans.
9 Can you just tell us a little bit more about that
10 method of measurement, and if there are ways in which that
11 could work better, because we certainly need the output of
12 that.
13 MS. O'KANE: I have no doubt that it could work
14 better, because I think when I look at that, I think it
15 raises as many questions as it answers. So I think you
16 recall, because you've sat on the CPM when we were debating
17 all of this, that there were many questions about what
18 exactly are we measuring here, and what can we attribute to
19 the plan, and so forth.
20 We haven't dug in and done a study of what we've
21 learned from that. That would be something I think very
22 much worth doing. I'm sorry, I think that the whole

1 strategy remains somewhat cloudy in terms of its goals and
2 in terms of the questions that we can really answer.
3 MR. MULLER: Let me add to the commendation of the
4 presentations and also note how congruent they were. I
5 think if we were sitting here five years ago we probably
6 would have had more variation in the themes that you
7 presented. So that the fact that the leaders in this field
8 are coming together more fully on the intellectual
9 construct, I think, is important.
10 Let me come to the theme of accountability. Peggy
11 said, in part, that she was in favor of more responsibility
12 at the physician group level and it comes through in Jack
13 and Sam's presentations, as well. The evidence, whether
14 it's from the Wennberg people or the Health Affairs article
15 that was in the presentation, indicated that with our very
16 disaggregated system, we have a mismatch between what we're
17 spending and what we're getting.
18 The advice I'd like to ask you is what kind of
19 measures the Medicare program could take to have more
20 accountability inside the system? I'll take Peggy's slide
21 that's up there as a convenient way. Most of the discussion
22 and the questioning today has been really more along the

1 vertical axis, in terms of the responsibility at the plan
2 and provider level. Sam's last comment spoke a little bit
3 to some of the incentives perhaps at the beneficiary or the
4 consumer level now, in terms of incentives, to be more
5 accountable in terms of their choices.
6 So lots of discussion today on the employer and
7 the beneficiary or consumer side, more discussion today on
8 the plan and provider site.
9 But what kind of steps would you suggest Medicare
10 be taking to have more accountability for performance?
11 Obviously P4P is one of it, and Sam has suggested that some
12 of the measures of payment at the 1 or 2 percent level for
13 larger groups like hospitals, perhaps 10 at the physician
14 level may be sufficient.
15 But as we try to get more accountability inside
16 the system, I mean, like Arnie, can go back and cite 30
17 years of where this meter hasn't moved as much as we want.
18 And Jack did say there's a lot of space on the right of his
19 chart to show that performance could be improved.
20 What are the kind of steps that we could be taking
21 within Medicare to more dramatically have accountability for
22 performance so we're not sitting -- maybe not in 110 years

1 as Arnie has implied -- but to move this a little faster
2 down the path?
3 MS. O'KANE: I'll start. One really easy thing to
4 do is take the HEDIS measures and really specify them in a
5 way that enables -- we torture ourselves and torture the
6 data to make comparisons about value adds for plans. But
7 people still don't trust it. So I think that there's a way
8 of really benchmarking by getting the management really
9 consistent across plans and fee-for-service Medicare.
10 I think for the CCIP project, we also ought to be
11 using the same kind of logic. So all these different
12 strategies, I think there are common metrics that could be
13 applied across the different strategies to see what we're
14 getting.
15 I actually think that we could measure
16 discoordination. So if we took redundant testing, for
17 example, as a metric of discoordination we could measure
18 that in the unintervened with delivery service and within
19 plans as another value add.
20 So I think we could sit down and really come up
21 with a set of measures pretty easily, starting with existing
22 ones, and just have a really robust strategy of really

1 quantifying value add.

2 MR. EBELER: I think it's a terrific question and

3 again, pay for performance is but one of many tools. I

4 think one of the advantages of it that I've always seen is

5 that it pulls with it better data because you can have a lot

6 of data that are reported and people can be a little bit

7 sloppy about it. But if you're going to start losing money

8 around based on it, you'll end up with better data. So I do

9 think transparency is vital here.

10 The difficulty I think that we've always faced in

11 health care is that -- comparing it to the Lake Woebegone

12 phenomenon, where there is a presumption that all of our

13 care is above average and all of the beneficiaries are below

14 average, which explains why some of the care isn't above

15 average. And it's very frightening to go out to your

16 community and say we're pretty good at this because we're

17 getting an 81. But in effect, that's sort of what we do in

18 health care.

19 And I don't they know how Medicare can lead in

20 that effort other than to get good data out there. This

21 Commission and Dr. McClellan are very courageous people. I

22 don't think they're going to wander around town to town and

1 say things are really bad out here. But somehow I think
2 transparency and then getting folks to understand that there
3 are dramatic differences in what you are likely to get if
4 you walk into that door at that community network in
5 Minnesota than if you walk into that door. And a dramatic
6 difference if you get that care in Minnesota compared to
7 Miami.
8 I don't know how to get to that second one, but at
9 some point we've got to deal with this phenomenon that the
10 introductory sentence that we all used to say that I no
11 longer say anymore, we've got the greatest health care
12 system in the world, is something that -- get 5 million
13 beneficiaries on our side. And I don't personally believe
14 giving them a lot of coinsurance is the way to do that. But
15 you get them on our side, this will change like that.
16 I don't know how to solve that, Ralph, but I think
17 that's part of the difficulty here.
18 MR. HACKBARTH: Do you see signs that we're
19 getting any better at providing information about technical
20 quality that patients can use, that they're interested in,
21 and that will affect where they go for care?
22 DR. NUSSBAUM: That's a great question. I'd like

1 to respond to that, Mr. Chairman, along with Ralph's.
2 Because I think all of the strategies should be aimed at
3 encouraging people to join organized systems of care. An
4 organized system of care can be the Senator's care
5 communities, it can be Jack your extraordinarily strong
6 organizations. It could be health plans that offer
7 beneficiaries disease and care management programs that
8 really help fill those current gaps that we have today. So
9 the organized system of care.
10 The other approach that I think we need to
11 consider and embrace is really an investment now, not over
12 20 years, but make the investment. Some have called it the
13 Marshall Plan for health and technology, health improvement
14 technology, to really fund that personal health record, to
15 fund the electronic health record. That will enable us to
16 at least remove these very expensive redundancies. So the
17 first step will be stopping redundancies. The second will
18 actually be stopping care that is not evidence-based that
19 doesn't lead to good outcomes.
20 The third step in that is actually going to be at
21 the point of care, the point of service, messaging to make
22 sure the care is delivered well.

1 I think as we enter the new, as we await the
2 Medicare Part D drug benefit, I think we're going to see
3 that with drugs we have the most extraordinary opportunity
4 that all of us -- and you have the most extraordinary
5 opportunity. Because drugs are delivered real-time. Drugs
6 do improve care for chronic disease. Drugs have NDC codes
7 and you can know at that moment where there will be a drug
8 interaction or not, or whether it's the right therapy. So I
9 would suggest that there is that opportunity for us to make
10 that investment. If we make it now it will reap magnificent
11 financial and clinically improved benefits over the much
12 longer term.
13 DR. MILLER: Just on this point, and I think this
14 is trying to be the different way to ask that question.
15 In any of your experience, when you've tiered
16 providers either on quality or quality and efficiency or
17 however you've thought of it, have you seen changes in the
18 way that beneficiaries or insurers go and seek their care?
19 Did it happen? And if so, do you have any sense on what
20 drove those changes?
21 DR. NUSSBAUM: If I may, I failed to answer that
22 part of the earlier question.

1 We have a number of quality tools that are
2 available that are web-based quality tools. Some have been
3 developed by neutral organizations such as SBEMO [ph].
4 They're called Health Advocate. They're available on our
5 websites to our members. And you can actually drill down to
6 look at hospital performance. So you can drill down and see
7 how many procedures were done, Leapfrog measures, actual
8 mortality and complication rates.
9 It's not driving very much change. And we're
10 disappointed in that so we have people visiting that
11 website. We're encouraging people, through the development
12 of higher performing networks.
13 But the assumption, and we've seen it -- it's more
14 than a decade in New York State and Pennsylvania -- all of
15 that measurement, even in ways that are understandable,
16 whether it's one or five stars, doesn't drive change at the
17 provider level.
18 Now Peggy obviously will speak to what this has
19 all meant in terms of accreditation and driving performance
20 at the health plan level. But I would have thought that,
21 particularly for elective significant procedures, that
22 people would exhibit different behaviors and they generally

1 haven't.

2 MS. O'KANE: I think it's early days. I think the

3 information that's out there is pretty limited at the

4 moment.

5 We actually just got -- somebody sent us an

6 abstract of a report that was presented at the NBER,

7 National Bureau of Economic Research, a paper that showed

8 that people did use health plan information. They seemed to

9 select higher quality health plans.

10 I think where there's a robust strategy that the

11 payer sticks with, you can show real results. Like General

12 Motors has had a very consistent steerage to higher quality

13 plans initiative going for a number of years. They have

14 basically moved masses of their employees into their higher

15 performing plans.

16 I think the experience with tiered networks is new

17 and we need to recognize that. Some early experience that

18 Sam Ho talks about at PacificCare shows that when they have

19 incentives for patients to go to higher performing medical

20 groups, they will follow those incentives.

21 So when the financial incentive is aligned with

22 what the quality information is telling them, I think people

1 do listen and do pay attention.

2 MR. EBELER: I would reinforce the General Motors

3 example as one of the best out there. It's not a defined

4 contribution model, it is literally jiggering the corporate

5 contribution in such a way that the enrollee faces a very

6 dramatically different premium for going to the highest

7 performing networks.

8 Mark, I'd be glad to query some of my members to

9 get some examples for you if you'd like, of within network

10 performance, to be a little more accurate on that score. I

11 have not seen a lot where information alone does it.

12 MR. HACKBARTH: Let me just ask one more question

13 on this point.

14 Several months ago Mark McClellan gave a speech in

15 which, if I understood him correctly, he was saying that now

16 that we've changed the pricing mechanism for Medicare

17 Advantage and we've moved from a strictly administered price

18 toward one that is at least competitively based through the

19 bidding process, that we may not need P4P in Medicare

20 Advantage, that we have a market-based system and the

21 beneficiaries, through this more competitive system, can

22 drive the necessary change.

1 Hearing what all of you just said in response to
2 the earlier questions, I guess I'm inferring that you would
3 disagree with that, if I'm understanding Mark correctly.
4 And that you think that even in a competitively-based system
5 pay for performance is important in driving the system in
6 the proper direction? Am I interpreting your comments
7 correctly?
8 DR. NUSSBAUM: I think that what we have seen is
9 that we can measure efficiency of networks, of physicians
10 and hospitals, efficiency meaning cost. We can do that
11 extremely well. We can construct, and we have, networks
12 that are based on cost. But those networks are not
13 necessarily of high quality. And I think that really the
14 opportunity for all of us is to advance quality, obviously
15 because we think in the longer term that will lead to less
16 devastating health consequences, you know, and better health
17 outcomes.
18 There's also an unintended consequence. If we
19 just built it on cost, then we're not encouraging quality.
20 What we've also seen, and it's not true for you
21 but in the commercial sector we've seen that when we've
22 actually shown hospitals that they're very terrific on

1 quality and have a good cost position, the unintended
2 consequence, of course, is well why aren't we paid far more
3 than those hospitals that are have a poor cost position?
4 Again, that will not be an issue for Medicare to
5 the same extent that it is for the commercial payers.
6 DR. REISCHAUER: But in Medicare Advantage the
7 beneficiary has Peggy's measures so they have some
8 indication of quality. And then the new payment mechanism
9 is going to drive parsimonious use of resources. So
10 wouldn't Mark say well, that's enough, we've got the two
11 things here. Do you have to then go in and then vary the
12 payment by quality?
13 MS. O'KANE: I would point to the results that I
14 showed you for the HEDIS measures, which are nothing to brag
15 about. I mean, compared to the commercial results.
16 And remember that the benes don't have the
17 benchmark information. I know I'm hammering on this point.
18 So they see rates of 65 or 80 percent and they think well,
19 none of these looks particularly good, especially because
20 the putative number for the uninterferred with system is 100
21 percent; right?
22 MR. EBELER: In some ways, the logic can be

1 reversed. There's an enormous amount on the plate of
2 Medicare Advantage plans and CMS right now that I think
3 you've got to respect. But as you move to a more
4 competitive pricing system, and it's a pretty small move in
5 the first couple of years, there is not any evidence from
6 the commercial market that a purely price competitive
7 system, with some information to folks, Peggy's data has
8 been out there a long time, is moving the quality needle.
9 The data we're looking at, in effect, are a commercial
10 market demonstration test of that hypothesis. And it's not
11 working.

12 I guess I would say if Medicare is able to attract
13 a lot more Medicare Advantage plans, not only to their
14 traditional participants like many of my members but new
15 plans, take advantage of that, take advantage of these new
16 entities that can collect and measure and start moving money
17 around at this very time to push the quality agenda.

18 While I think you've got to be careful about
19 loading too many things on the plate at one time, I think
20 we've tested, in many ways, that hypothesis in the
21 commercial market and quality hasn't jumped out, in part
22 because -- the Commission said it before, Dr. Reischauer --

1 the beneficiary is moving based on the satisfaction
2 indicators. Very important, and we don't discount that.
3 They're not moving based on the quality indicators. In
4 fact, we've done some quick correlations between CAHPS
5 measures, HEDIS measures and utilization measures, and it
6 appears that CAHPS is more responsive to higher utilization
7 than it is to higher quality. That would be my rebuttal to
8 that.
9 DR. REISCHAUER: Could it also be that a
10 disproportionate fraction of the high-quality performers are
11 nonprofit organizations and aren't particularly motivated by
12 expansion? So they aren't going out there and saying Group
13 Health has the best HEDIS measure of anybody by 40 percent,
14 come on down.
15 MS. O'KANE: Come on, diabetics, come join my
16 plan. Now that you've got risk-adjusted payment, maybe that
17 will change. I think it will change. The reward for
18 accountable plans in a market that's generally not
19 accountable is kind of plus/minus because I think there is
20 this feeling that they are going to attract sick people.
21 DR. REISCHAUER: There's then an issue of do we do
22 risk adjustment right.

1 MS. O'KANE: Right.

2 DR. REISCHAUER: You can usually change the risk
3 adjustment measure so the plan would want them to come.

4 MS. O'KANE: Right and that is a difference.

5 I would beg to differ with Jack that it hasn't
6 made a difference. In the plans, we see 50 percent
7 increases over four years on a whole bunch of very important
8 measures. But the sad news is the market has not rewarded
9 that. We don't have that kind of risk adjustment.

10 MR. HACKBARTH: Regrettably, we're running short
11 on time. I have Alan and Jay. Anybody else on this side?
12 Alan.

13 DR. NELSON: I want to drill down a little deeper
14 on pay for efficiency, with efficiency being one of the six
15 IOM quality aims defined as reducing waste, and particularly
16 within the fee-for-service part of Medicare.

17 One of our dilemmas is assigning responsibility
18 for resource use to any particular physician or group. Do
19 you have experience with grouping software? What other
20 comments do you have in terms of rewarding efficiency in
21 fee-for-service Medicare where competitive bidding doesn't
22 play a role?

1 MS. O'KANE: We have a benchmarking project that
2 is actually -- it is a bunch of physician-centric
3 measurement projects around the country where we're trying
4 to come up with some common rules and so on. And this
5 attribution issue is one of the things that we're trying to
6 work out a formula for.
7 I think if you think about it, though, I mean
8 imagine that you're a physician and you've seen a patient
9 one time and the patients costs are really high. And all of
10 a sudden you're part of this moving accountability network
11 that you didn't even know you were a part of. To me, there
12 is a sort of practical aspect of is that doesn't quite shake
13 itself out.
14 If you think about measuring efficiency at the
15 individual doctor level, and each individual doctor is doing
16 the right thing but they're all doing the same thing for the
17 patient, what you have there is not an efficient practice
18 pattern collectively. And that's one of the reasons that I
19 keep coming back to it's got to be bigger than a bread box.
20 It's got to be bigger than a single physician.
21 Now it is useful, and there's been very good
22 progress made in some markets, and Arnie knows about this

1 like in Las Vegas, with elimination of outlier, you know,
2 people that are way beyond the norms in terms of their
3 utilization patterns. But that really isn't going to get us
4 to where we need to get in terms of the efficiency that we
5 need out of this health care system.
6 DR. NUSSBAUM: There are many, many tools. They
7 are generally episode treatment groupers. Arnie is very
8 expert in this area.
9 But what we found is how you attribute and
10 interpret and use those tools. For example, if you're
11 looking at efficiency measures and a specialist is linked
12 with a hospital, often his or her cost efficiency will be
13 determined by the practice of that hospital as one
14 possibility. Now all of that can be adjusted for it.
15 We find that while you start grouping clinicians
16 together, how do you group specialists? And even in the
17 area let's say of diabetes, do you group primary care
18 doctors and internists and then diabetologists and then
19 diabetologists that take care of particularly complex
20 diabetics?
21 And while there are all these approaches that can
22 attempt to diminish and improve the risk adjustment, they're

1 not perfect yet.

2 So one of the things that we've done in our

3 performance measurements and rewards is when we have groups

4 we've tried to create that reward at the group level rather

5 than the individual physician level. Obviously for smaller

6 clusters of physicians it is more dependent on the

7 individual physician. That's one way to try to encourage

8 more efficiency within the group and more collaboration

9 within that group.

10 DR. CROSSON: Thank you.

11 I'd like to compliment you all on the

12 presentations, but even more than that on your leadership

13 over a long period of time. It's been very valuable.

14 I think what I'd like to do, and I'll do it

15 briefly, is to extract from your presentations those things

16 which fit my own prejudice, roll them together, and then see

17 if I have a question.

18 Sam, you presented that sort of scheme of all the

19 great ideas in the last 20 years and the fact that there has

20 at least been some secular change in those things. I wonder

21 myself if it's not going to turn out to be cyclical. But

22 one of the concerns is that the next version of this will

1 have pay for performance and a number of other things like
2 disease management on the list 10 years from now.
3 Pay for performance is one of horses that we've
4 decided to ride. And for a lot of reasons, it would be
5 useful for it to be successful in the end. It seemed to me,
6 and it's mostly come out in the discussion here so I won't
7 belabor it, that if that's going to happen there probably
8 need to be three transitions that occur. One of those is
9 the transition from limited claims data to more robust
10 clinical data. And I think you mentioned that.
11 The second one is something in the area of
12 improvement of the unit of measurement. There are probably
13 two parts to that. One would be movement from the plan
14 level to the provider level. And then at the provider level
15 movement from disaggregation to aggregation of some kind.
16 That has values, both in terms of attribution as well as
17 statistical power for actually being able to compare things.
18 The third one, and it's interesting because my
19 mind is churning now based on your question. But I would
20 have said movement to include efficiency so that we get to a
21 value equation. Now whether that's going to become as
22 important in Medicare Advantage with the competitive model,

1 I'm not sure. But if you presume that we are going to move
2 more to the delivery level, and if you presume that
3 incentives for efficiency at the level of delivery are
4 important, then I would probably say it's still going to be
5 required. Because otherwise even the competitive bidding
6 model at the plan level is just going to raise the water.
7 So I would still probably include the idea that
8 movement towards efficiency is important.
9 So my question in all this, and some of it has
10 been answered so don't be redundant, is what do you think we
11 should do in advocating or recommending measures and
12 structure for pay for performance in Medicare Advantage to
13 try to accelerate each one of those three characteristics
14 which would lead to a more robust pay for performance in the
15 end?
16 MS. O'KANE: We're all kind of boggled by it.
17 DR. NUSSBAUM: First of all, I think we agree with
18 your consensus development of what we've all said and what
19 the discussion has been.
20 But one theme is when you look at Medicare
21 Advantage plans, you will perhaps propose some of these
22 quality metrics. What then should be imperative for those

1 of us who manage these plants is really to drive them to the
2 level of delivery of services. And I know the roll up at
3 sort of the overarching strategy level which we're speaking,
4 it should occur. But I think we have to do a much better
5 job to touch true elements of care.
6 And again, not to give one example, we look at
7 breast imaging as an important measure of will women get
8 appropriate care if they have breast cancer. But think
9 about, that's the first and very modest step in a whole
10 sequence of will the right care be given by a surgeon or
11 radiation oncologist? Will the right chemotherapy be used?
12 Will the right elements of care, in terms of our new
13 understanding of the molecular events for certain women and
14 the new therapy?
15 So these have to be driven, and I absolutely agree
16 with your overarching statement, these have to be driven to
17 far better care in the delivery system. And holding the
18 plans accountable for that with their networks, with
19 physicians, we'll get there.
20 While we're talking about Medicare Advantage, I
21 think that all of these programs get wrapped around
22 everything else that CMS and Medicare does for its

1 beneficiaries. I think it is, as you've mentioned the CCIP
2 care and disease management programs. it is the programs
3 that have been discussed in oncology or end-stage renal
4 disease.
5 So to me it's driving it to the level of the
6 specific provider of care will make the ultimate difference,
7 and to get specificity ultimately that matters in outcomes.
8 MR. EBELER: A couple of things. I think that the
9 Commission can help set a clear road map. And I think one
10 of the things that the health care community needs in
11 looking at this is a sense that something is going to be
12 happening in this area for the next 10 or 15 years. It is
13 not another interesting payment tool, little lever that
14 we're going to turn on for three or four years and then turn
15 off. I think that message actually is getting out, your
16 consistent message. Again, we've been delighted that folks
17 like Senators Grassley and Baucus have given that signal.
18 So in part, a clarity of a road map, and it's why
19 we've always talked both short-term and long-term here.
20 I think the unit of measurement, getting it out to
21 the provider level. But I also think we all know they have
22 to be clinically relevant and meaningful. We have to do it

1 in a way that's meaningful for a patient. And just again,
2 not to lean too hard on the Minnesota example, but when you
3 look at what they've done there, in the example of diabetes,
4 it's not just reporting the statistic on eye exams and
5 statistics on renal exams and statistics on whether things
6 are tested and things are under control. They compute a
7 statistic about whether a diabetic patient got everything
8 there were supposed to get on the schedule that is
9 appropriate and are at the appropriate levels of control?
10 And you get a yes or a no. So performance is now not at
11 81/82. In some cases it's down to 10 or 15 because you
12 might miss one.
13 For a diabetic patient, that strikes me as more
14 relevant. If I go to this particular network clinic versus
15 that one, is the stuff that's going to happen to me going
16 happen? And I think that also helps drive the systems-ness
17 issue because it's not simply a matter of figuring out your
18 testing mechanism. It's figuring out whether you get it.
19 So I think that unit of measure not only driving
20 it down to delivery but coming up with things that force
21 health care to behave around these things in a systemic way
22 and in ways that are a little articulate for the patient as

1 they come forward.

2 I think on the effectiveness and value, I
3 absolutely agree, it's got to be part of this. My caution
4 in some ways of just having observed the health plan
5 community over many years, if pay for performance ends up
6 being interpreted by the physician community and the
7 patients as are you guys cutting costs again, I worry that
8 we could lose it.

9 So yes, it's got to be a part of it because it's
10 clearly part of the agenda here. I think we believe that it
11 is, in fact, associated with the higher quality agenda. But
12 I just think you want to make sure that we don't lose the
13 credibility if you accept the hypothesis that we really have
14 to be pointing this way and getting everybody signed on to
15 this agenda.

16 MS. O'KANE: There is so much work that we need to
17 do, and I think the challenge of moving to the provider
18 level can't be overestimated. We have a couple of new
19 recognition programs starting in specialty care, one for
20 cancer interestingly, one for spine care. But there's so
21 much to be done. We are actually reaching out to a lot of
22 the specialty societies really trying to get some

1 consistency. Patients tend to see more than one doctor, so
2 again we don't want to have these kind of overly focused
3 specialty measures that at the end of the day don't add up
4 to something coherent.
5 I think, as you know, you kind of gave me this
6 opportunity. But I've been encouraging the Council of
7 Accountable Physician Practices to kind of step up with your
8 information systems and so forth and really kind of lead the
9 way in driving an accountability agenda. I really think you
10 can. You have the wherewithal, you have the organization at
11 the ground level.
12 And then those QIOs that are spending all that
13 money out there, we could get them aligned around having
14 comparable information that would have to be pulled out of
15 charts for the fee-for-service side at the provider level.
16 So I think that there is a huge agenda that could
17 be moved forward with the money that we're currently
18 spending.
19 MR. DURENBERGER: Glenn, just to make the point
20 that this is not waiting on Kaiser, while all the results of
21 that Minnesota study are blinded, the best performer in
22 Minnesota is not the Mayo Clinic, it's not some big

1 multispecialty group in the Twin Cities. It's 12 docs in a
2 little place up on Lake Superior who have figured out how to
3 do it as close to 100 percent as possible without pouring
4 huge resources into it.
5 MR. HACKBARTH: We're going to have to bring it to
6 a close. Thanks again? A terrific job, very informative.
7 Thanks again for all the work you've done in the past. We
8 appreciate it.
9 [Applause.]
10 MR. HACKBARTH: We will have a brief public
11 comment period. And if we have anybody going to the
12 microphone, please keep in mind that I know some of the
13 commissioners need to leave quickly for airplanes.
14 That's just the right length for right now.
15 So thank you all and we will see you in October.
16 [Whereupon, at 11:49 a.m., the meeting was
17 adjourned.]